Our Performance in 2022-23

This section of the report compares results with targets for both financial and non-financial indicators and explains significant variations. It also provides information on achievements during the year, major initiatives and projects, and explains why this work was undertaken.

Summary of Performance

Key Performance Indicators

The *Parliamentary Commissioner Amendment (Reportable Conduct) Act 2022* received Royal Assent on 19 August 2022. The Act amends the *Parliamentary Commissioner Act 1971* and establishes a legislated Reportable Conduct Scheme in Western Australia. The Ombudsman's Outcome Based Management structure, including Key Performance Indicators, has been revised to include the Reportable Conduct Scheme. The Scheme commenced on 1 January 2023.

Key Effectiveness Indicators

The Ombudsman aims to improve decision making and administrative practices in public authorities as a result of complaints handled by the Office, reviews of certain child deaths and family and domestic violence fatalities and own motion investigations. Improvements may occur through actions identified and implemented by agencies as a result of the Ombudsman's investigations and reviews, or as a result of the Ombudsman making specific recommendations and suggestions that are practical and effective.

Key Effectiveness Indicators are the percentage of these recommendations and suggestions accepted by public authorities and the number of improvements that occur as a result of Ombudsman action.

The Key Effectiveness Indicators now also include the percentage of recommendations and suggestions accepted by relevant entities under the Reportable Conduct Scheme and the number of actions taken by relevant entities to prevent reportable conduct.

Key Effectiveness Indicators	2021-22 Actual	2022-23 Target	2022-23 Actual	Variance from Target
Where the Ombudsman made recommendations to improve practices or procedures, the percentage of recommendations accepted by agencies	100%	100%	**100%**	Nil
Number of improvements to practices or procedures as a result of Ombudsman action	57	100	**75**	-25
Where the Ombudsman made recommendations regarding reportable conduct, the percentage of recommendations accepted by relevant entities	Not applicable - the new Reportable Conduct function commenced on 1 January 2023		**Not applicable**	Not applicable
Number of actions taken by relevant entities to prevent reportable conduct	Not applicable - the new Reportable Conduct function commenced on 1 January 2023		**26**	Not applicable

Another important role of the Ombudsman is to enable remedies to be provided to people who make complaints to the Office where service delivery by a public authority may have been inadequate. The remedies may include reconsideration of decisions, more timely decisions or action, financial remedies, better explanations and apologies. In 2022-23, there were 273 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman.

Comparison of Actual Results and Budget Targets

Public authorities have accepted every recommendation made by the Ombudsman, matching the actual results of the past four years and meeting the 2022-23 target.

In 2007-08, the Office commenced a program to ensure that its work increasingly contributed to improvements to public administration.

The 2022-23 actual number of improvements to practices and procedures of public authorities as a result of Ombudsman action (75) differs from the 2022-23 target (100) and the 2021-22 actual (57) as there are fluctuations in improvements from year to year, related to the number, nature and outcomes of investigations finalised by the Office in any given year.

On 1 January 2023, the Ombudsman commenced a new function to undertake the Reportable Conduct Scheme (**the Scheme**). Accordingly, there was no 2022-23 target for the Key Effectiveness Indicator 'Number of actions taken by relevant entities to prevent reportable conduct'. There were no Recommendations made in the first six months of the operation of the Scheme and, as such, the Key Effectiveness Indicator, 'Where the Ombudsman made recommendations regarding reportable conduct, the percentage of recommendations accepted by relevant entities' is not applicable.

Key Efficiency Indicators

The Key Efficiency Indicators relate to timeliness of complaint handling, the cost per finalised allegation about public authorities, the cost per finalised notification of child deaths and family and domestic violence fatalities, the cost per notification of reportable conduct, and the cost of monitoring and inspection functions.

Key Efficiency Indicators	2021-22 Actual	2022-23 Target	2022-23 Actual	Variance from Target
Percentage of allegations finalised within three months	97%	95%	**96%**	+1%
Percentage of allegations finalised within 12 months	100%	100%	**100%**	Nil
Percentage of allegations on hand at 30 June less than three months old	96%	90%	**93%**	+3%
Percentage of allegations on hand at 30 June less than 12 months old	100%	100%	**100%**	Nil
Average cost per finalised allegation	$1,749	$1,890	**$1,547**	-$343
Average cost per finalised notification of death	$17,097	$17,500	**$8,415**	-$9,085
Average cost per notification of reportable conduct	Not applicable – the new Reportable Conduct function commenced on 1 January 2023		**$6,027**	Not applicable
Cost of monitoring and inspection functions	$516,576	$767,000	**$735,183**	-$31,817

Comparison of Actual Results and Budget Targets

The 2022-23 actual results for all Key Efficiency Indicators met, or exceeded the 2022-23 target, with the exception of the 'Cost of monitoring and inspection functions'. Overall, 2022-23 actual results represent sustained efficiency of complaint resolution over the last five years, including that since 2007-08, the efficiency of complaint resolution has improved significantly with the average cost per 31ublic31ed allegation reduced by a total of 47% from $2,941 in 2007-08 to $1,547 in 2022-23.

The 2022-23 actual average cost per 31ublic31ed notification of death ($8,415) is lower than the 2022-23 target ($17,500) and the 2021-22 actual ($17,097) as a result of the Ombudsman commencing a new jurisdiction to review all child deaths that occur in Western Australia. In 2022-23, the office of the Ombudsman 31ublic31ed a number of notifications received since the commencement of this expanded child death review function. This resulted in an increase in the number of notifications 31ublic31ed in 2022-23, and a subsequent reduction in the average cost per notification.

The 2022-23 actual cost of monitoring and inspection functions ($735,183) is higher than the 2021-22 actual ($516,576) as a result of the commencement of, and funding for, a new function for the Ombudsman under amendments to the *Liquor Control Act 1988*.

For further details, see the Key Performance Indicator section.

Summary of Financial Performance

The majority of expenses for the Office (77%) relate to staffing costs. The remainder is primarily for accommodation, communications and office equipment.

Financial Performance	2021-22 Actual ('000s)	2022-23 Target ('000s)	2022-23 Actual ('000s)	Variance from Target ('000s)
Total cost of services (sourced from Statement of Comprehensive Income)	**$11,422**	$13,394	**$12,611**	-$783
Income other than income from State Government (sourced from Statement of Comprehensive Income)	**$2,582**	$2,720	**$2,685**	-$35
Net cost of services (sourced from Statement of Comprehensive Income)	**$8,840**	$10,674	**$9,926**	-$748
Total equity (sourced from Statement of Financial Position)	**$368**	$860	**$1,524**	+$664
Net increase/decrease in cash held (sourced from Statement of Cash Flows)	**-$58**	$20	**$1,229**	+$1,209

Comparison of Actual Results and Budget Targets

The 2022-23 actual results for both the total and net cost of services are comparable to the 2022-23 targets and the 2021-22 actual.

For further details see Note 9 'Explanatory Statement' in the Financial Statements section.

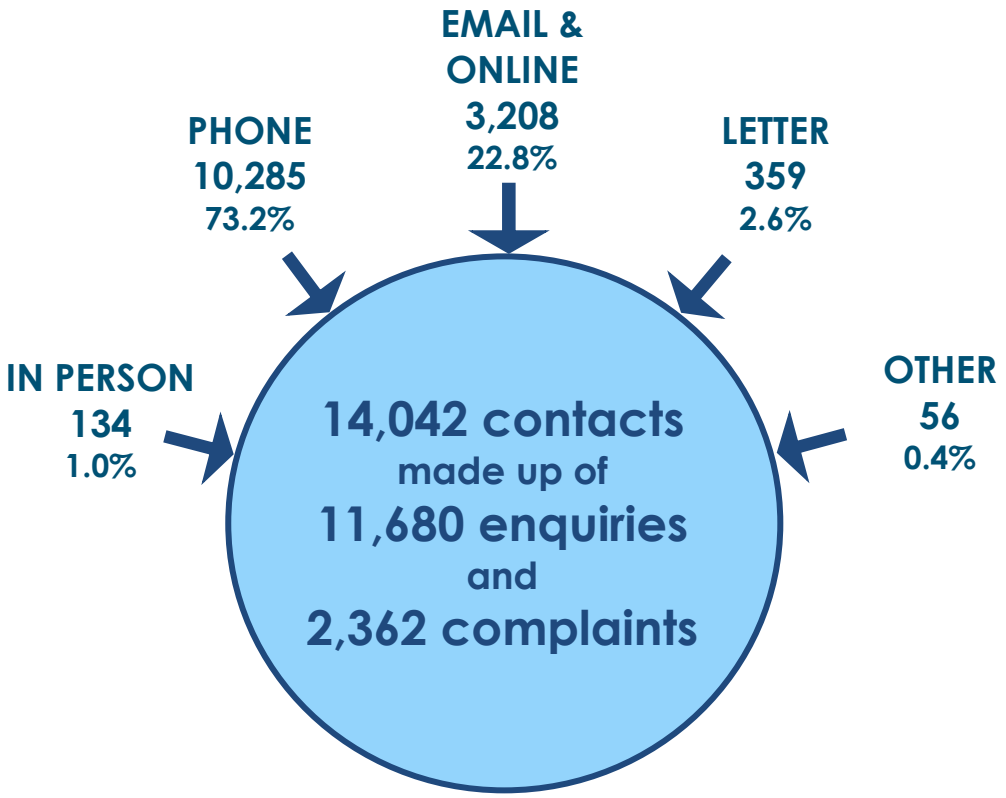
Complaint Resolution

A core function of the Ombudsman is to resolve complaints received from the public about the decision making and practices of State Government agencies, local governments and universities (commonly referred to as public authorities). This section of the report provides information about how the Office assists the public by providing independent and timely complaint resolution and investigation services or, where appropriate, referring them to a more appropriate body to handle the issues they have raised.

Contacts

In 2022-23, the Office received 14,042 contacts from members of the public consisting of:

- 11,680 enquiries from people seeking advice about an issue or information on how to make a complaint; and
- 2,362 written complaints from people seeking assistance to resolve their concerns about the decision making and administrative practices of a range of public authorities.

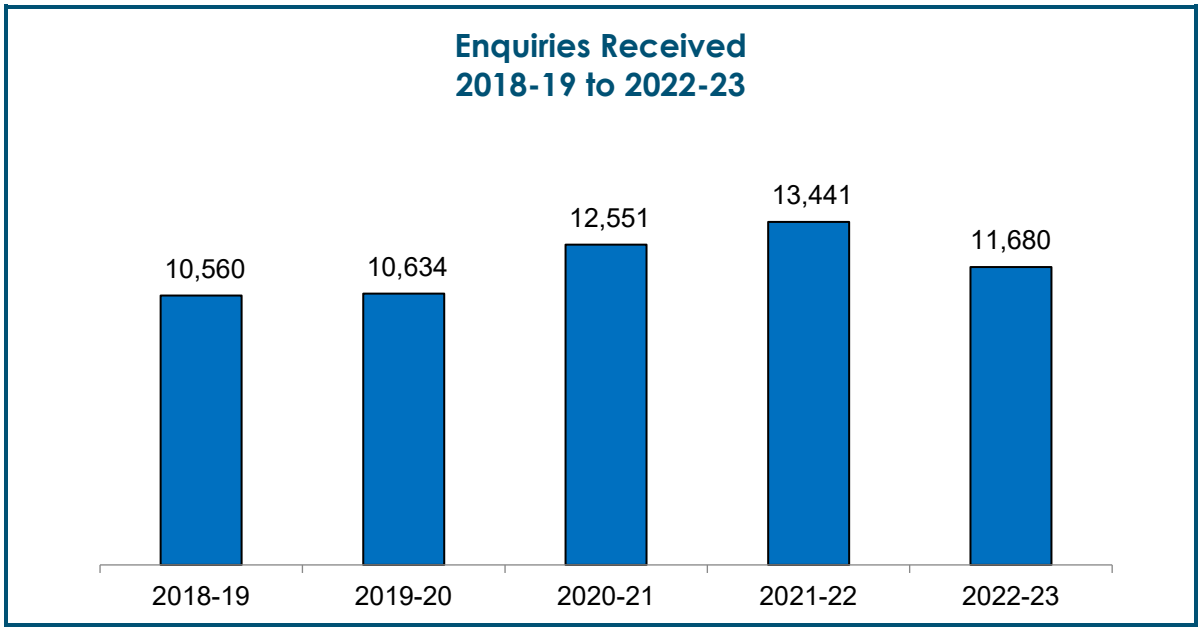


Enquiries Received

There were 11,680 enquiries received during the year.

For enquiries about matters that are within the Ombudsman's jurisdiction, staff provide information about the role of the Office and how to make a complaint. For approximately half of these enquiries, the enquirer is referred back to the public authority in the first instance to give it the opportunity to hear about and deal with the issue. This is often the quickest and most effective way to deal with the issue. Enquirers are advised that if their issues are not resolved by the public authority, they can make a complaint to the Ombudsman.

For enquiries that are outside the jurisdiction of the Ombudsman, staff assist members of the public by providing information about the appropriate body to handle the issues they have raised.

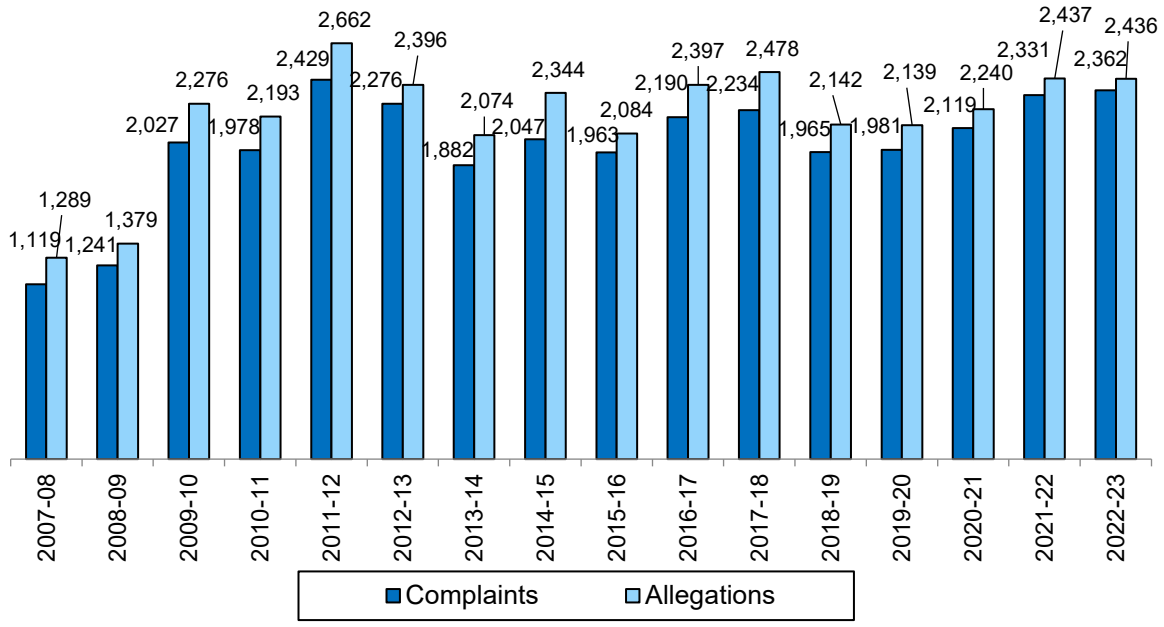


Enquirers are encouraged to try to resolve their concerns directly with the public authority before making a complaint to the Ombudsman.

Complaints Received

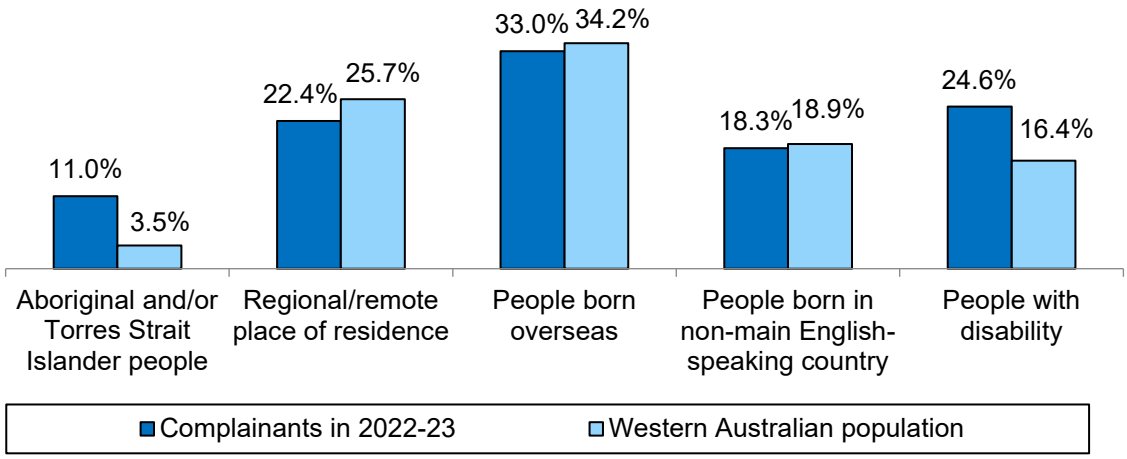
In 2022-23, the Office received 2,362 complaints, with 2,436 separate allegations, and finalised 2,308 complaints. There are more allegations than complaints because one complaint may cover more than one issue.

Total Number of Complaints and Allegations Received 2007-08 to 2022-23



Note: The number of complaints and allegations shown for a year may vary in this and other charts by a small amount from the number shown in previous annual reports. This occurs because, during the course of an investigation, it can become apparent that a complaint is about more than one public authority or there are additional allegations with a start date in a previous reporting year.

Characteristics of Complainants in 2022-23

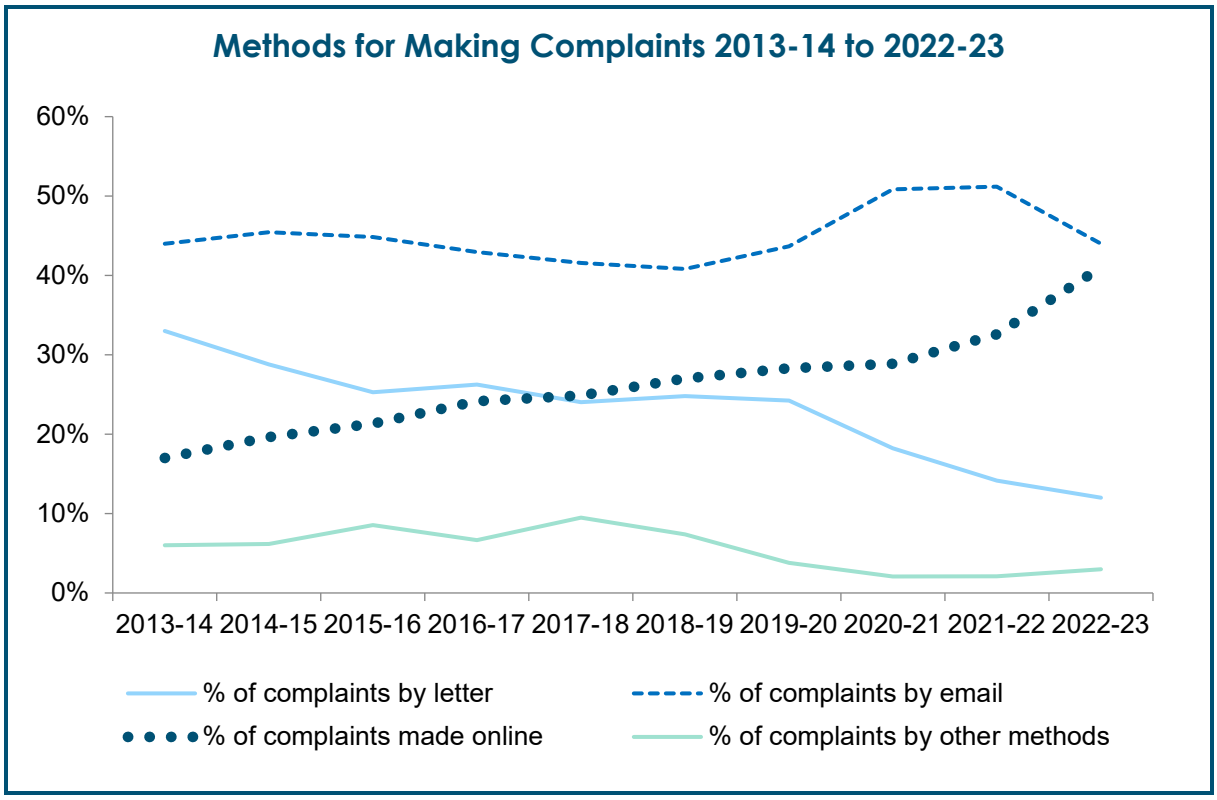


Note: Non-main English-speaking countries as defined by the Australian Bureau of Statistics are countries other than Australia, the United Kingdom, the Republic of Ireland, New Zealand, Canada, South Africa and the United States of America. Being from a non-main English-speaking country does not imply a lack of proficiency in English.

How Complaints Were Made

Over the last 15 years, the use of email and online facilities to lodge complaints has increased from 29% in 2008-09 to 85% in 2022-23. Over the same time, the proportion of people who lodge complaints by letter has declined from 64% to 12%.

In 2022-23, 44% of complaints were lodged by email, 41% through the Office's online complaint form, 12% by letter and three per cent by other methods including during regional visits and in person.



Resolving Complaints

Early resolution involves facilitating a timely response and resolution of a complaint.

Where it is possible and appropriate, staff use an early resolution approach to investigate and resolve complaints. This approach is highly efficient and effective and results in timely resolution of complaints. It gives public authorities the opportunity to provide a quick response to the issues raised and to undertake timely action to resolve the matter for the complainant and prevent similar complaints arising again. The outcomes of complaints may result in a remedy for the complainant or improvements to a public authority's administrative practices, or a combination of both. Complaint resolution staff also track recurring trends and issues in complaints and this information is used to inform broader administrative improvement in public authorities and investigations initiated by the Ombudsman (known as own motion investigations).

Time Taken to Resolve Complaints

Timely complaint handling is important, including the fact that early resolution of issues can result in more effective remedies and prompt action by public authorities to prevent similar problems occurring again. The Office's continued focus on timely complaint resolution has resulted in ongoing improvements in the time taken to handle complaints.

Timeliness and efficiency of complaint handling has substantially improved over time due to a major complaint handling improvement program introduced in 2007-08. An initial focus of the program was the elimination of aged complaints.

Building on the program, the Office developed and commenced a new organisational structure and processes in 2011-12 to promote and support early resolution of complaints. There have been further enhancements to complaint handling processes in 2022-23, in particular in relation to the early resolution of complaints.

Together, these initiatives have enabled the Office to maintain substantial improvements in the timeliness of complaint handling.

In 2022-23:

- The percentage of allegations finalised within 3 months was 96%; and
- The percentage of allegations on hand at 30 June less than 3 months old was 93%.

96% of allegations were finalised within 3 months.

Following the introduction of the Office's complaint handling improvement program in 2007-08, very significant improvements have been achieved in timely complaint handling, including:

- The average age of complaints has decreased from 173 days to 37 days; and
- Complaints older than 6 months have decreased from 40 to 4.

Complaints Finalised in 2022-23

There were 2,308 complaints finalised during the year and, of these, 1,541 were about public authorities in the Ombudsman's jurisdiction. Of the complaints about public authorities in jurisdiction, 1,000 were finalised at initial assessment, 497 were finalised after an Ombudsman investigation and 44 were withdrawn.

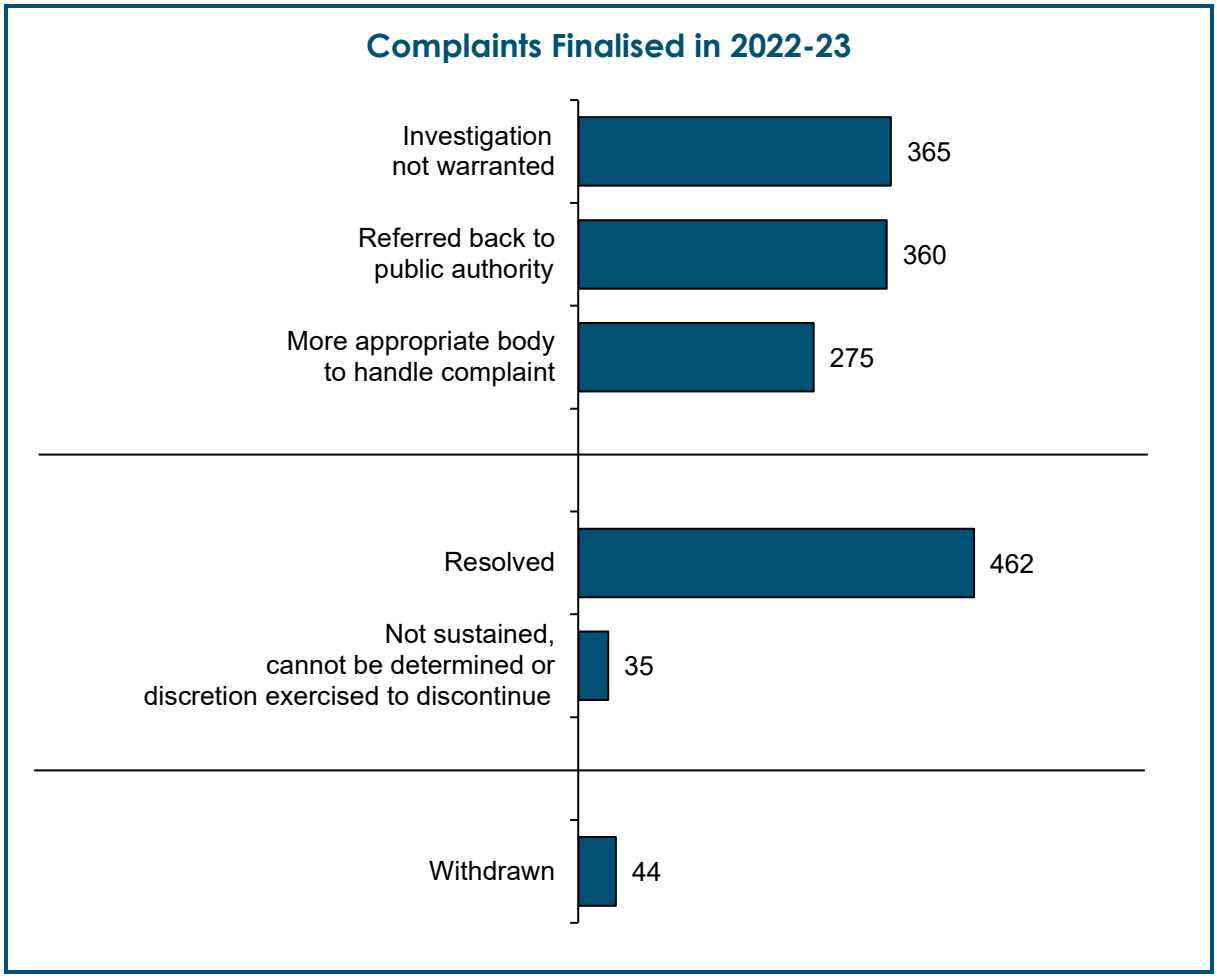
Complaints finalised at initial assessment

Over a third (36%) of the 1,000 complaints finalised at initial assessment were referred back to the public authority to provide it with an opportunity to resolve the matter before investigation by the Ombudsman. This is a common and timely approach and often results in resolution of the matter. The person making the complaint is asked to contact the Office again if their complaint remains unresolved. In a further 275 (28%) of the complaints finalised at initial assessment, it was determined that there was a more appropriate body to handle the complaint. In these cases, complainants are provided with contact details of the relevant body to assist them.

Complaints finalised after investigation

Of the 497 complaints finalised after investigation, 91% were resolved through the Office's early resolution approach. This involves Ombudsman staff contacting the public authority to progress a timely resolution of complaints that appear to be able to be resolved quickly and easily. Public authorities have shown a strong willingness to resolve complaints using this approach and frequently offer practical and timely remedies to resolve matters in dispute, together with information about administrative improvements to be put in place to avoid similar complaints in the future.

The following chart shows how complaints about public authorities in the Ombudsman's jurisdiction were finalised.

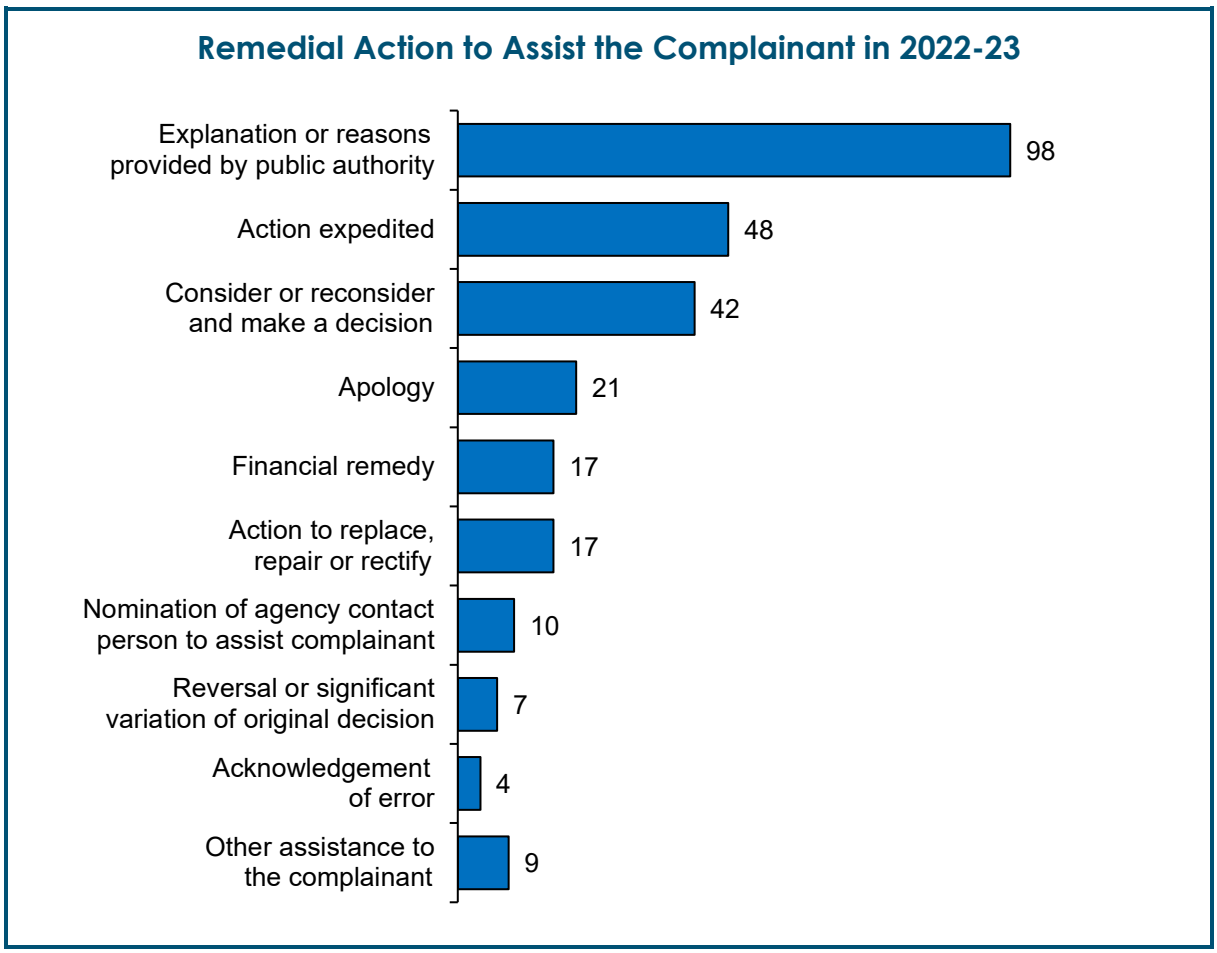


Note: Investigation not warranted includes complaints where the matter is not in the Ombudsman's jurisdiction.

Outcomes to assist the complainant

Complainants look to the Ombudsman to achieve a remedy to their complaint. In 2022-23, there were 273 remedies provided by public authorities to assist the individual who made a complaint to the Ombudsman. In some cases, there is more than one action to resolve a complaint. For example, the public authority may apologise and reverse their original decision. In a further 80 instances, the Office referred the complaint to the public authority following its agreement to expedite examination of the issues and to deal directly with the person to resolve their complaint. In these cases, the Office follows up with the public authority to confirm the outcome and any further action the public authority has taken to assist the individual or to improve their administrative practices.

The following chart shows the types of remedies provided to complainants.



Case Study

Vehicle transfer error corrected

A person bought a vehicle and a few days later sold the vehicle. They attended the public authority's centre to pay the transfer fees for the purchase and submit the paperwork for both the purchase and subsequent sale of the vehicle. The public authority applied the payment to the sale transfer instead of the purchase transfer in error. Subsequently, the person received a fine from the public authority for non-payment of the purchase transfer fee.

The person complained to the public authority about the error and provided evidence of the transfer fee payment. The public authority did not accept the evidence provided and requested further information. The person complained to the Ombudsman.

Following the Ombudsman's involvement, the public authority investigated the matter and confirmed that an error had occurred. The public authority corrected its records to show that the transfer had been paid and placed the fine on hold. The public authority wrote to the person to inform them of the outcome.

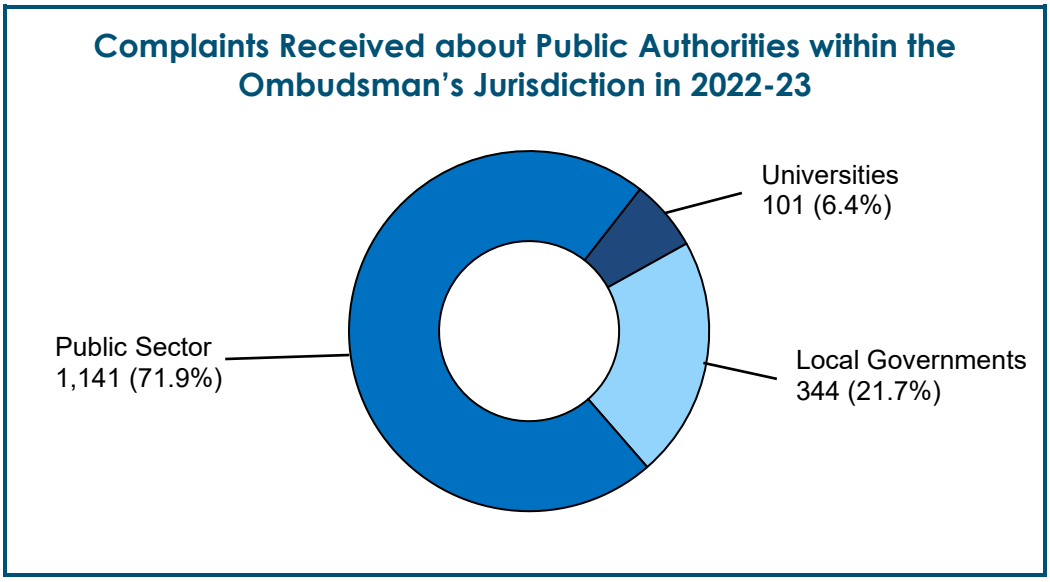
Outcomes to improve public administration

In addition to providing individual remedies, complaint resolution can also result in improved public administration. This occurs when the public authority takes action to improve its decision making and practices in order to address systemic issues and prevent similar complaints in the future. Administrative improvements include changes to policy and procedures, changes to business systems or practices and staff development and training.

About the Complaints

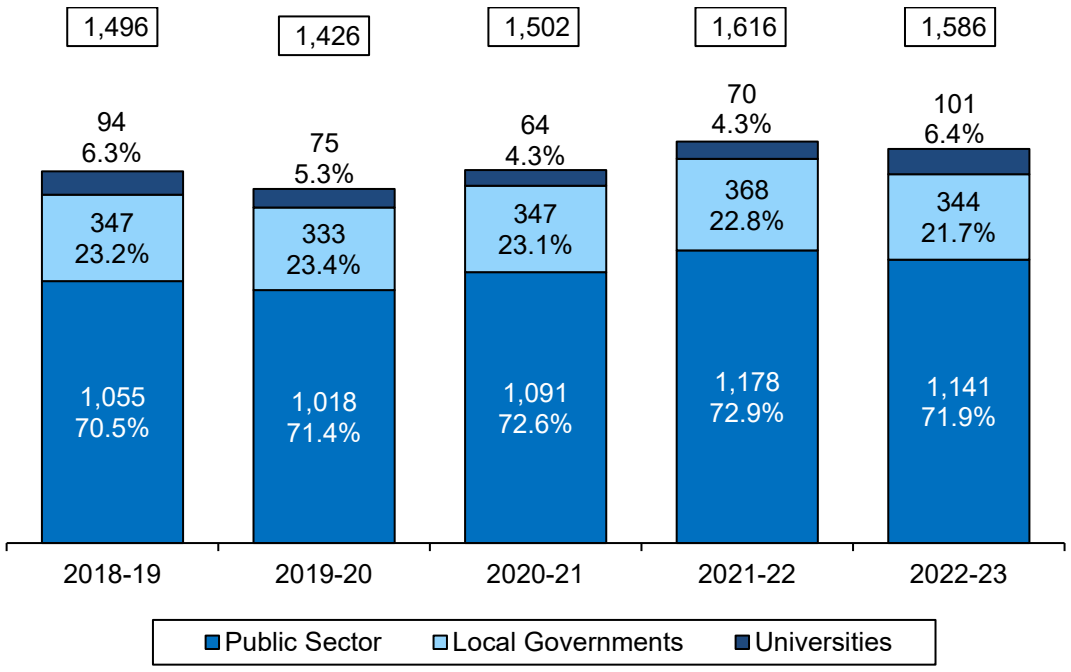
Of the 2,362 complaints received, 1,586 were about public authorities that are within the Ombudsman's jurisdiction. The remaining 776 complaints were about bodies outside the Ombudsman's jurisdiction. In these cases, Ombudsman staff provided assistance to enable the people making the complaint to take the complaint to a more appropriate body.

Public authorities in the Ombudsman's jurisdiction fall into three sectors: the public sector (1,141 complaints) which includes State Government departments, statutory authorities and boards; the local government sector (344 complaints); and the university sector (101 complaints).



The proportion of complaints about each sector in the last five years is shown in the following chart.

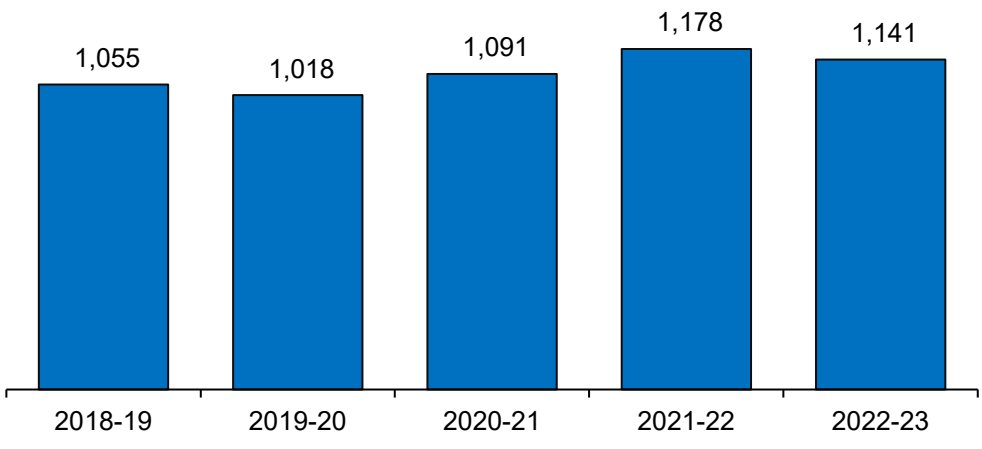
Complaints Received about Public Authorities within the Ombudsman's Jurisdiction between 2018-19 and 2022-23



The Public Sector

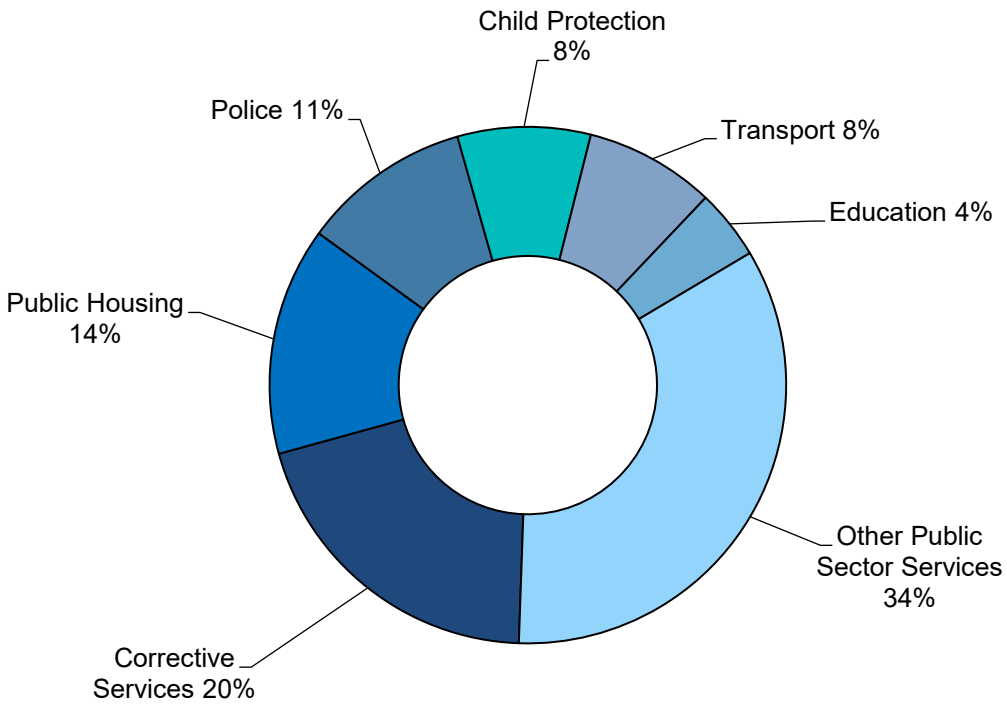
In 2022-23, there were 1,141 complaints received about the public sector and 1,120 complaints were finalised. The number of complaints about the public sector as a whole since 2018-19 is shown in the chart below.

Complaints Received about the Public Sector between 2018-19 and 2022-23



Public sector agencies deliver a very diverse range of services to the Western Australian community. In 2022-23, complaints were received about key services as shown in the following chart.

Complaints Received about the Public Sector in 2022-23



Of the 1,141 complaints received about the public sector in 2022-23, 66% were about six key service areas covering:

- Corrective services, in particular prisons (230 or 20%);
- Public housing (163 or 14%);
- Police (121 or 11%);
- Child protection (95 or 8%);
- Transport (93 or 8%);
- Education, including public schools and TAFE colleges (50 or 4%). Information about universities is shown separately under the university sector.

For further details about the number of complaints received and finalised about individual public sector agencies and authorities, see Appendix 1.

Outcomes of complaints about the public sector

In 2022-23, there were 232 actions taken by public sector bodies as a result of Ombudsman action following a complaint. These resulted in 203 remedies being provided to complainants and 29 improvements to public sector practices.

The following case study illustrates the outcomes arising from complaints about the public sector. Further information about the issues raised in complaints and the outcomes of complaints is shown on the following pages for each of the six key service areas and for the other public sector services as a group.

Case Study

High water bills waived and apology provided

A tenant made repeated requests to the public authority that owned the property about high water bills and possible leaks in the reticulation for the property. A leak allowance credit was provided but the high bills continued. At the end of the tenancy, the tenant received a further high bill which included charges for the period after the tenancy. The tenant complained to the Ombudsman.

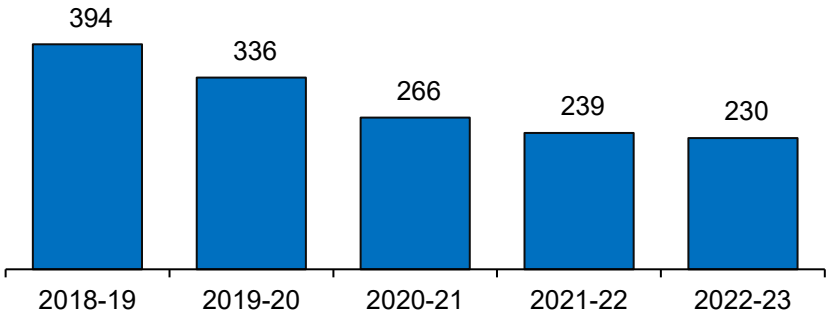
The Ombudsman contacted the public authority, which acknowledged that the tenant was charged for consumption after the tenancy period ended and placed a credit on the person's account. The Ombudsman requested that the public authority further investigate the tenant's concerns about the high bills and inform the tenant and the Ombudsman of the outcome.

The public authority reviewed the tenancy history and acknowledged that the tenant had made numerous reports about excessive water bills and possible water leaks from the reticulation which were not addressed in an effective and timely manner. The public authority apologised to the former tenant, waived further charges and provided a refund for the final high bill.

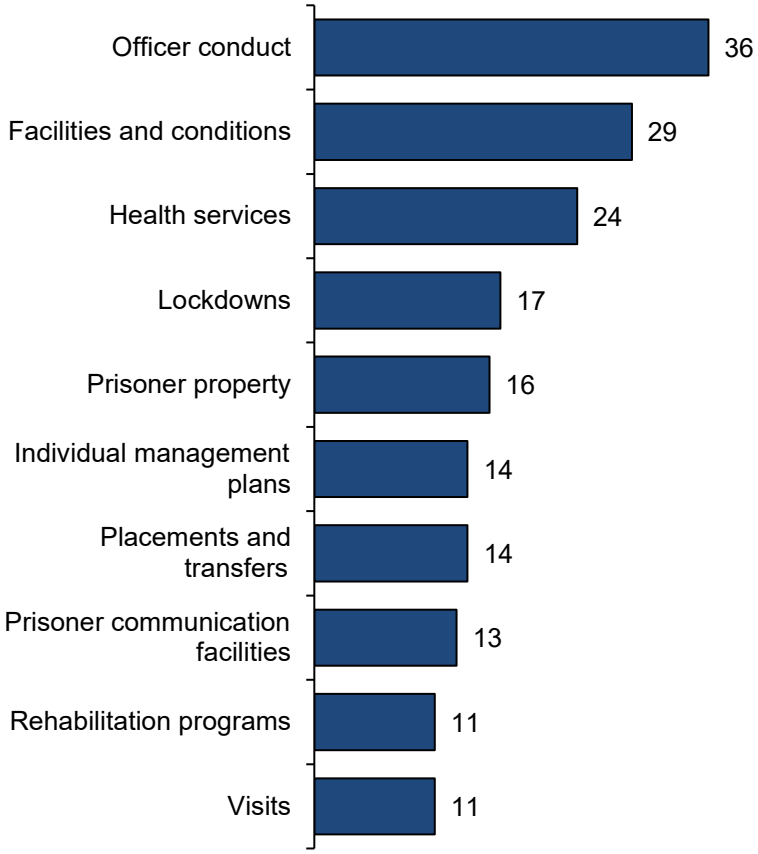
Public sector complaint issues and outcomes

Corrective Services

Complaints received



Most common allegations

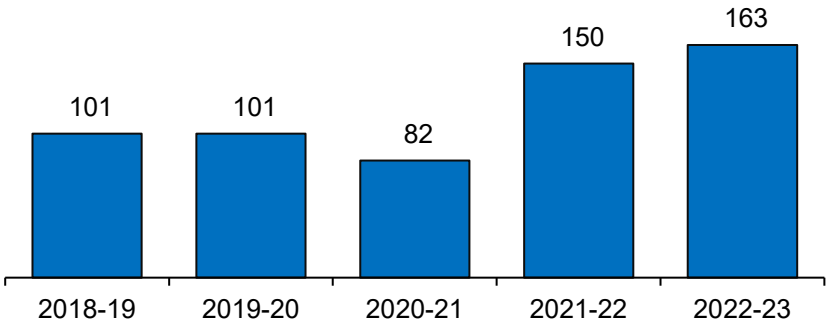


Outcomes achieved

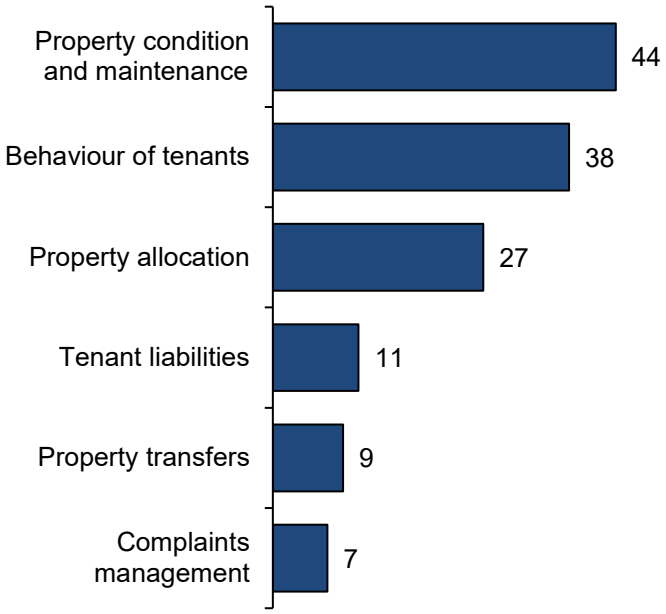
- Financial payment or monetary charge reduced;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Action expedited;
- Explanation given or reasons provided;
- Change to business systems or practices; and
- Staff training.

Public Housing

Complaints received



Most common allegations

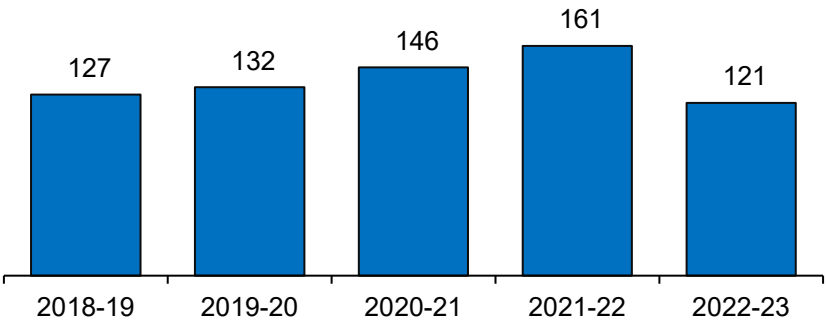


Outcomes achieved

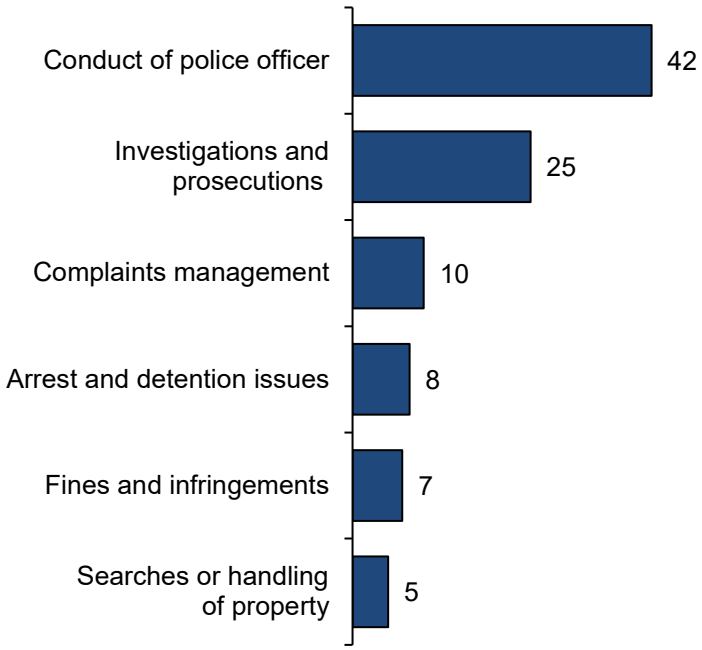
- Financial payment or monetary charge reduced or refunded;
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Acknowledgement of error;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to business systems or practices; and
- Staff training.

Police

Complaints received



Most common allegations

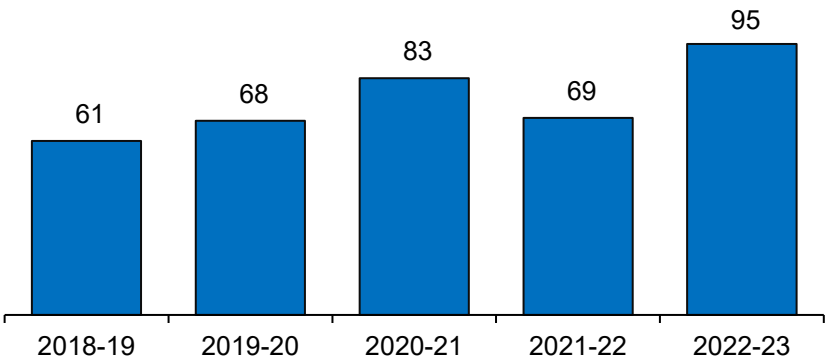


Outcomes achieved

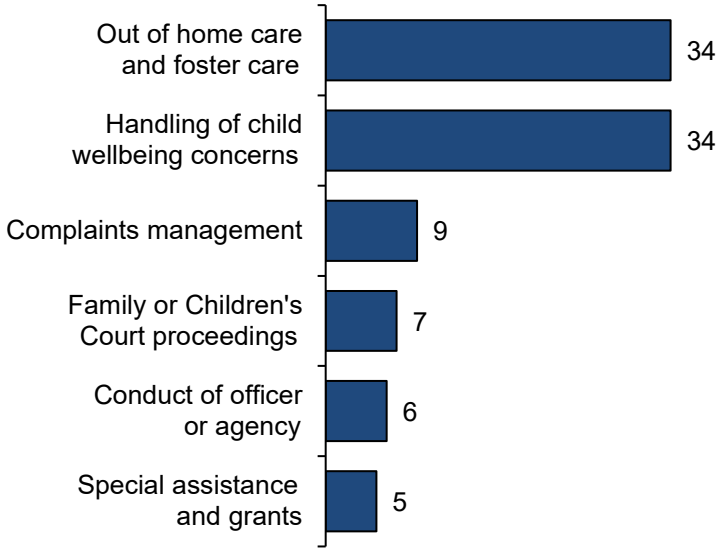
- Explanation given or reasons provided.

Child Protection

Complaints received



Most common allegations

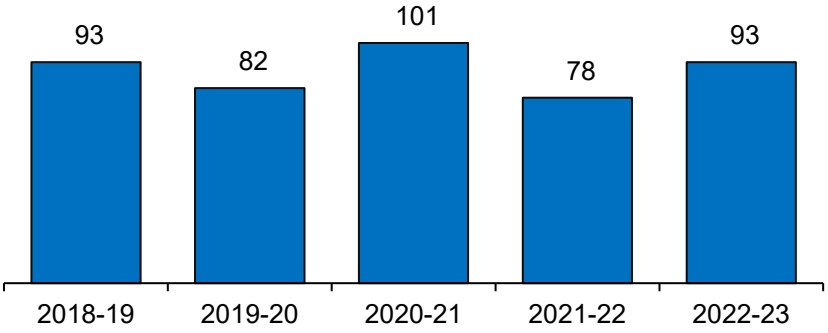


Outcomes achieved

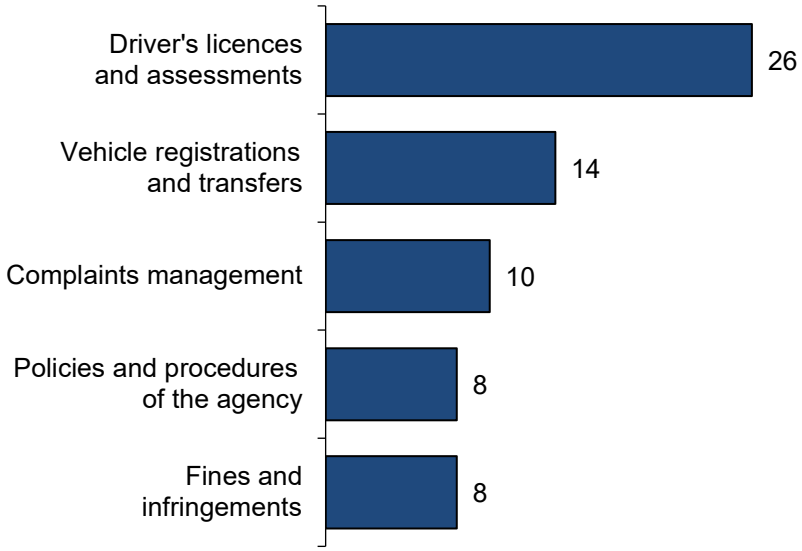
- Action to replace, repair or rectify a matter;
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Acknowledgement of error;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices;
- Conduct audit or review;
- Staff training.

Transport

Complaints received



Most common allegations

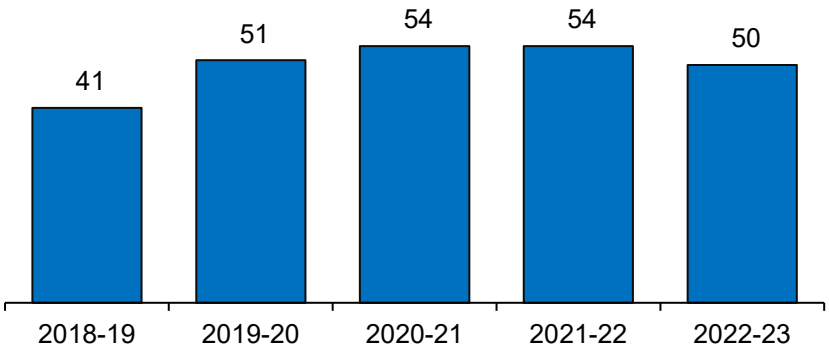


Outcomes achieved

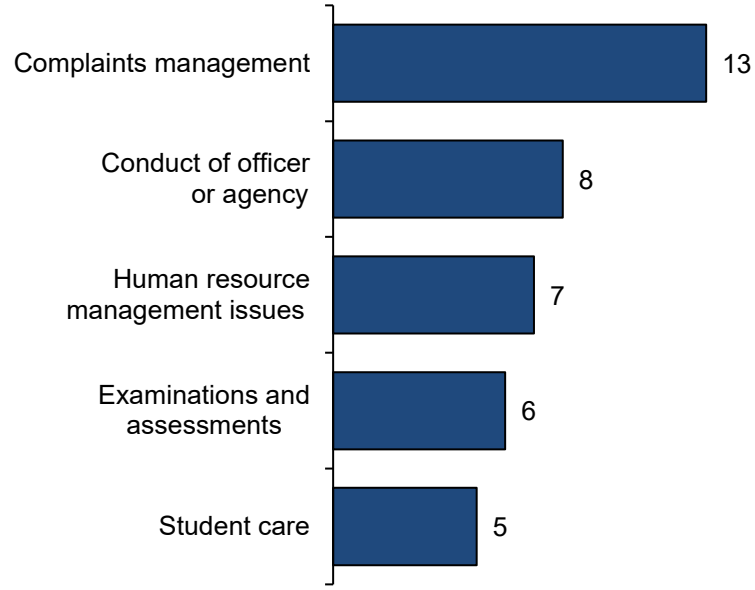
- Financial payment or monetary charge refunded;
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to business systems or practices; and
- Conduct audit or review.

Education

Complaints received



Most common allegations



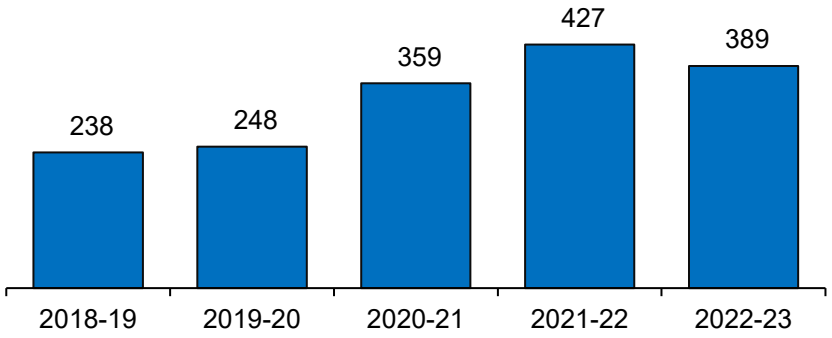
These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018* relating to TAFE colleges and other public education agencies. Further details on these appeals are included later in this section.

Outcomes achieved

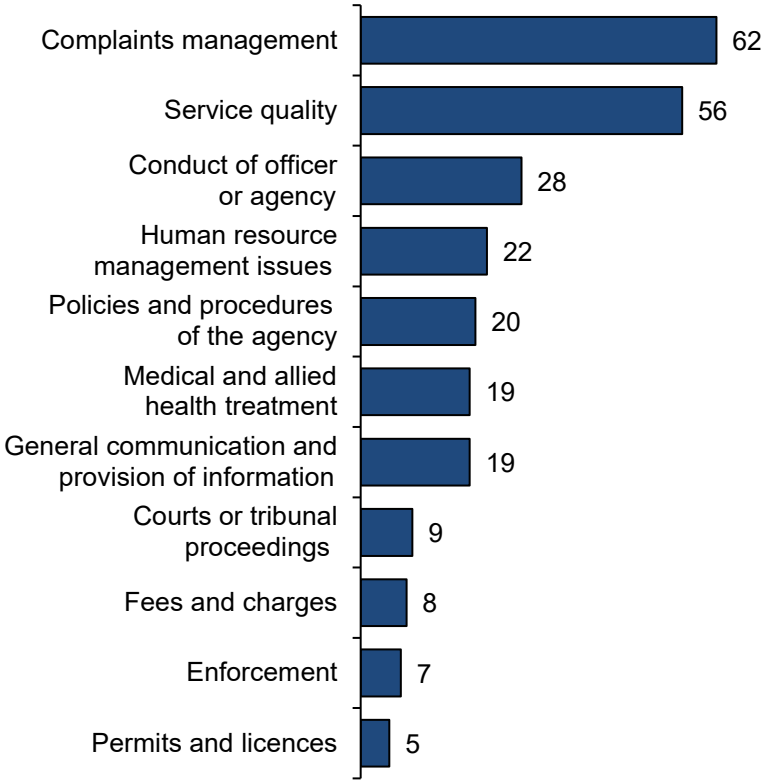
- Reversal or significant variation of original decision;
- Consider or reconsider a matter and make a decision;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to business systems or practices;
- Update to publications or website;
- Conduct audit or review; and
- Staff training.

Other Public Sector Services

Complaints received



Most common allegations



Outcomes achieved

- Financial payment or monetary charge reduced or withdrawn;
- Action to replace, repair or rectify a matter:
- Consider or reconsider a matter and make a decision;
- Apology given;
- Acknowledgment of error;
- Action expedited;
- Explanation given or reasons provided;
- Senior officer nominated to handle the matter;
- Change to business systems or practices;
- Conduct audit or review; and
- Staff training.

The following case studies provide an example of action taken by a public sector agency as a result of the involvement of the Ombudsman.

Case Study

Public authority takes reasonable steps to mitigate the impact of works

A person complained about the impact of works carried out by the public authority near the person's home. The works were causing significant dust pollution.

The Ombudsman's investigation considered the correspondence from the person to the public authority, the public authority's responses to the person, the public authority's dust management plan and the actions that the public authority had already taken to minimise the impact of the works on residents.

The Ombudsman found that the public authority had communicated regularly with affected residents before and during the works. The public authority had taken action based on resident feedback to improve its dust mitigation measures and had provided affected residents with vouchers for cleaning. Following the Ombudsman's enquiries, the public authority provided the person with an additional reimbursement for professional cleaning and committed to provide a final clean indoors and outdoors at the completion of the works. The Ombudsman's view was that the public authority's actions were reasonable in the circumstances.

Case Study

Public housing waitlist application reinstated

A person had their application for public rental housing withdrawn by the public authority as the person did not meet the eligibility criteria. The person appealed the decision as they said their circumstances were temporary and they should not have to reapply for assistance. The public authority upheld its original decision. The person complained to the Ombudsman.

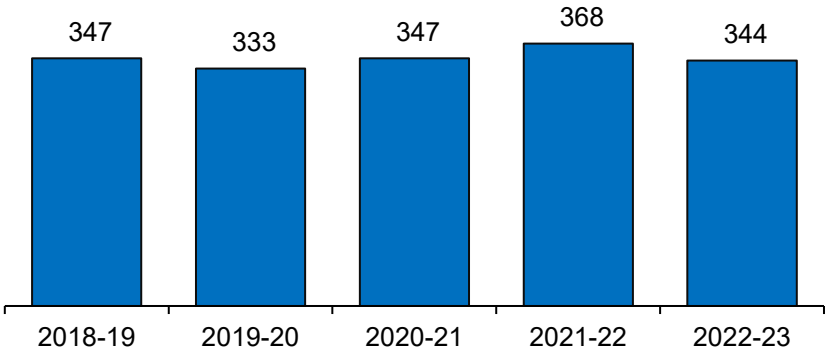
The Ombudsman's investigation found that the public authority had followed its policies about the person's eligibility but identified further extenuating circumstances for the person that the public authority had not considered in the original appeal. The Ombudsman referred the information to the public authority so that it may reconsider the matter and inform the person and the Ombudsman of the outcome. The public authority subsequently reinstated the person's public rental housing application based on the original application date and wrote to the person to inform them of this outcome.

The local government sector

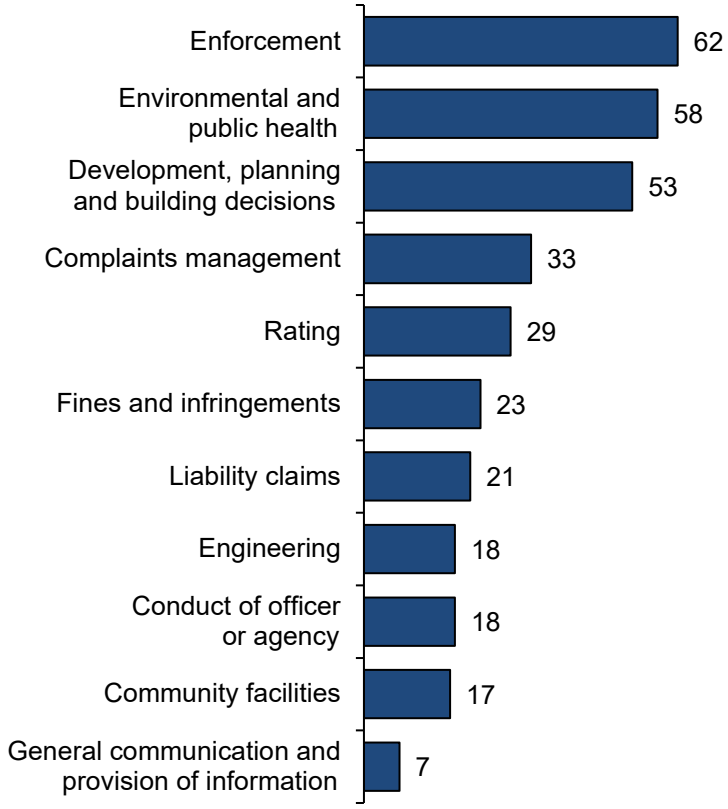
The following section provides further details about the issues and outcomes of complaints for the local government sector.

Local Government

Complaints received



Most common allegations



Outcomes achieved

- Monetary charge withdrawn;
- Action to replace, repair or rectify a matter;
- Consider or reconsider a matter and make a decision;
- Apology given;
- Acknowledgement of error;
- Action expedited;
- Explanation given or reasons provided;
- Change to policy, procedure, business systems or practices;
- Conduct audit or review; and
- Staff training.

Case Study

Community visit to a regional town leads to improved facilities

The office of the Ombudsman visited a regional town as part of its Regional Awareness and Accessibility Program. During the visit, members of the community raised concerns about the lack of access to public toilets and drinking water fountains or taps in the town. The Ombudsman took written complaints during the visit to enable the office to investigate the issue.

In response to the Ombudsman's enquiries with the local government, the local government provided information about the current availability of public toilets and drinking water in the town. The local government explained some public toilet facilities normally open during the day have been kept locked over recent months due to staffing issues. The local government said it was rostering necessary staff and had commenced a planning exercise to install additional drinking fountains through the town.

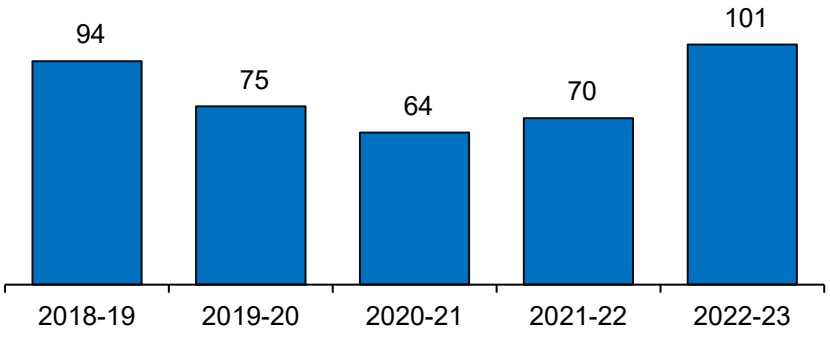
Following the Ombudsman's investigation, the local government confirmed that it would be opening the locked public toilets, had started remediation of a public toilet, and has repaired a broken water fountain. The local government also said it is undertaking a review of toilet facilities and water fountains throughout the town to inform funding needs and the future works program.

The university sector

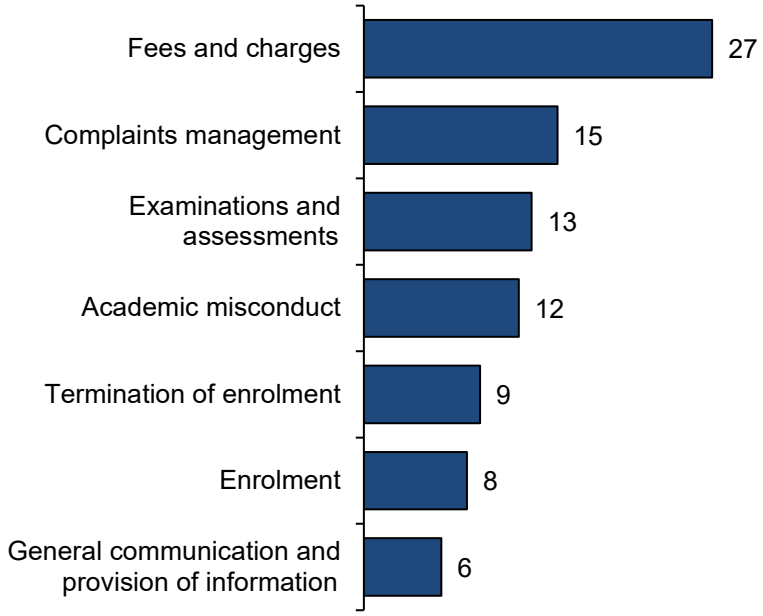
The following section provides further details about the issues and outcomes of complaints for the university sector.

Universities

Complaints received



Most common allegations



These figures include appeals by overseas students under the *National Code of Practice for Providers of Education and Training to Overseas Students 2018.* Further details on these appeals are included later in this section.

Outcomes Achieved

- Reversal or significant varying of original decision;
- Consider or reconsider a matter and make a decision;
- Action expedited;
- Explanation given or reasons provided;
- Conduct audit or review;
- Change to policy, procedure, business systems or practices;
- Improved record keeping; and
- Staff training.

Other Complaint Related Functions

Reviewing appeals by overseas students

The *National Code of Practice for Providers of Education and Training to Overseas Students 2018* (**the National Code**) sets out standards required of registered providers who deliver education and training to overseas students studying in Australian universities, TAFE colleges and other education agencies. It provides overseas students with rights of appeal to external, independent bodies if the student is not satisfied with the result or conduct of the internal complaint handling and appeals process.

Overseas students studying with both public and private education providers have access to an Ombudsman who:

- Provides a free complaint resolution service;
- Is independent and impartial and does not represent either the overseas students or education and training providers; and
- Can make recommendations arising out of investigations.

In Western Australia, the Ombudsman is the external appeals body for overseas students studying in Western Australian public education and training organisations. The Overseas Students Ombudsman is the external appeals body for overseas students studying in private education and training organisations.

Case Study

University waives fees for survivor of domestic violence and makes improvements

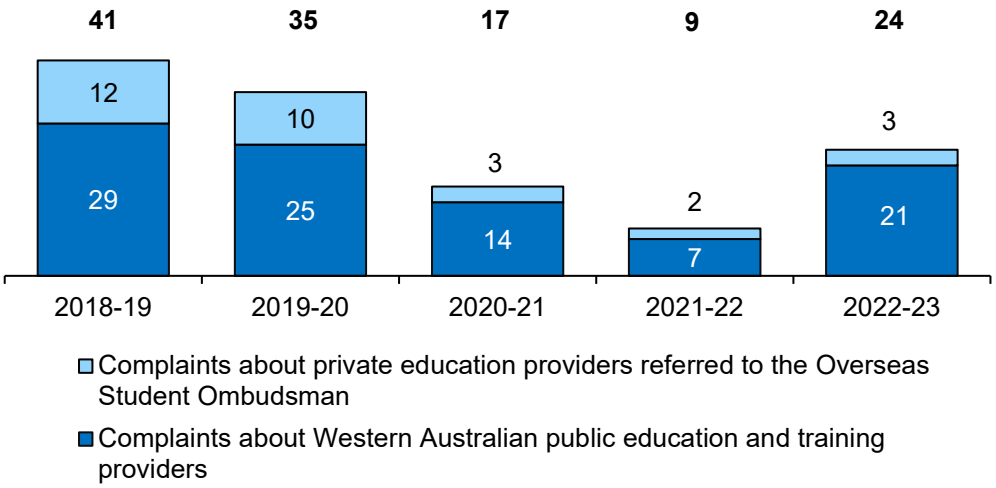
A university student experiencing domestic violence withdrew from their studies. The student thought that they would need to re-enrol in the future but discovered they were still enrolled in the next semester and had fees owing for the units of study. The student complained to the university about the fees as a survivor of domestic violence. The university upheld its original decision, as it said the student had adequate opportunity to withdraw from the units before the cut-off date and to provide further evidence to support their special circumstances. The student complained to the Ombudsman.

Following the Ombudsman's investigation, the university agreed to approve the student's withdrawal without financial penalty. The Ombudsman also discussed with the university its approach to communicating with survivors of domestic violence. The university subsequently implemented professional development for staff on trauma informed practice. The university also changed its systems to make it easier for unenrolled students to make online applications to withdraw without financial penalty.

Complaints lodged with the Office under the National Code

Education and training providers are required to comply with 11 standards under the National Code. In dealing with these complaints, the Ombudsman considers whether the decisions or actions of the agency complained about comply with the requirements of the National Code and if they are fair and reasonable in the circumstances.

Complaints Received from Overseas Students under the National Code between 2018-19 and 2022-23



During 2022-23, the Office received 24 complaints from overseas students, including 21 complaints about public education and training providers. All of the 21 complaints about public education providers within the Ombudsman's jurisdiction were about universities. The Office also received three complaints that, after initial assessment, were found to be about a private education provider. The Office referred these complainants to the Overseas Students Ombudsman.

The 21 complaints by overseas students about public education and training providers involved 21 separate allegations, relating to:

- Fees and charges (11);
- Termination of enrolment (4);
- Handling of academic misconduct allegations (2);
- Enrolment issues (2)
- Examinations and assessments (1); and
- Other issues (1).

During the year, the Office finalised 19 complaints by overseas students about public education and training providers.

Public Interest Disclosures

Section 5(3) of the *Public Interest Disclosure Act 2003* allows any person to make a disclosure to the Ombudsman about particular types of 'public interest information'. The information provided must relate to matters that can be investigated by the Ombudsman, such as the administrative actions and practices of public authorities, or relate to the conduct of public officers.

Key members of staff have been authorised to deal with disclosures made to the Ombudsman and have received appropriate training. They assess the information provided to determine whether the matter requires investigation, having regard to the *Public Interest Disclosure Act 2003*, the *Parliamentary Commissioner Act 1971* and relevant guidelines. If a decision is made to investigate, subject to certain additional requirements regarding confidentiality, the process for investigation of a disclosure is the same as that applied to the investigation of complaints received under the *Parliamentary Commissioner Act 1971*.

During the year, two disclosures were received.

Indian Ocean Territories

Under a service delivery arrangement between the Ombudsman and the Australian Government, the Ombudsman handles complaints about State Government departments and authorities delivering services in the Indian Ocean Territories and about local governments in the Indian Ocean Territories. There were no complaints received during the year.

Terrorism

The Ombudsman can receive complaints from a person detained under the *Terrorism (Preventative Detention) Act 2006*, about administrative matters connected with their detention. There were no complaints received during the year.

Requests for Review

Occasionally, the Ombudsman is asked to review or re-open a complaint that was investigated by the Office. The Ombudsman is committed to providing complainants with a service that reflects best practice administration and, therefore, offers complainants who are dissatisfied with a decision made by the Office an opportunity to request a review of that decision.

In 2022-23, three reviews were undertaken, representing 0.1 per cent of the total number of complaints finalised by the Office. In all cases, the original decision was upheld.

Child Death Review

Overview

This section sets out the work of the Office in relation to its child death review function. Information on this work has been set out as follows:

- Background;
- The role of the Ombudsman in relation to child death reviews;
- The child death review process;
- Analysis of child death reviews;
- Patterns, trends and case studies relating to child death reviews;
- Issues identified in child death reviews;
- Recommendations;
- Timely handling of notifications and reviews;
- Major own motion investigations arising from child death reviews;
- Other mechanisms to prevent or reduce child deaths; and
- Stakeholder liaison.

Background

In November 2001, prompted by the coronial inquest into the death of a 15 year old Aboriginal girl at the Swan Valley Nyoongar Community in 1999, the (then) State Government announced a special inquiry into the response by government agencies to complaints of family violence and child abuse in Aboriginal communities.

The resultant 2002 report, *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*, recommended that a Child Death Review Team be formed to review the deaths of children in Western Australia (Recommendation 146). Responding to the report, the (then) Government established the Child Death Review Committee (**CDRC**), with its first meeting held in January 2003. The function of the CDRC was to review the operation of relevant policies, procedures and organisational systems of the (then) Department for Community Development in circumstances where a child had contact with the Department.

In August 2006, the (then) Government announced a functional review of the (then) Department for Community Development. Ms Prudence Ford was appointed the independent reviewer and presented the report, *Review of the Department for Community Development: Review Report* (**the Ford Report**) to the (then) Premier in January 2007. In considering the need for an independent, inter-agency child death review model, the Ford Report recommended that:

- The CDRC together with its current resources be relocated to the Ombudsman (Recommendation 31); and
- A small, specialist investigative unit be established in the Office to facilitate the independent investigation of complaints and enable the further examination, at the discretion of the Ombudsman, of child death review cases where the child was known to a number of agencies (Recommendation 32).

Subsequently, the *Parliamentary Commissioner Act 1971* was amended to enable the Ombudsman to undertake child death reviews, and on 30 June 2009, the child death review function in the Office commenced operation.

In 2018, the (then) Minister for Health requested that the Office of the Chief Medical Officer within the Department of Health consider the establishment of a Child Death Register and comprehensive review mechanism for all child deaths in Western Australia. The Office of the Chief Medical Officer facilitated a series of stakeholder meetings, and in late 2019 it was determined that this function would be provided by the Ombudsman.

From 1 July 2020, the Ombudsman has received notifications of all child deaths in WA. Notification (and associated information) is provided by Communities, the Department of Health, and the Department of Justice, Registry of Births, Deaths and Marriages (**Births, Deaths and Marriages**). The Ombudsman:

- Considers all child deaths through the collection and analysis of state-wide data, including trend reporting (the WA Child Death Register); and
- Ensures all child deaths in the State are reviewed by the Ombudsman, or where appropriate, by an existing medical death review mechanism.

The Role of the Ombudsman in Relation to Child Death Reviews

The child death review function enables the Ombudsman to review investigable deaths. Investigable deaths are defined in the Ombudsman's legislation, the *Parliamentary Commissioner Act 1971* (see Section 19A(3)), and occur when a child dies in any of the following circumstances:

- In the two years before the date of the child's death:
    - The Chief Executive Officer (**CEO**) of the Department of Communities (**Communities**) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children and Community Services Act 2004*, the CEO had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child; and
    - Any of the actions listed in section 32(1) of the *Children and Community Services Act 2004* was done in respect of the child or a child relative of the child.

- The child or a child relative of the child is in the CEO's care or protection proceedings are pending in respect of the child or a child relative of the child.

In addition to determining if a child death is an investigable death, since 1 July 2020, the Ombudsman also identifies whether the child death will be reviewed by the Coroner (reportable deaths) or an existing medical review mechanism (including *Perinatal and infant mortality review committee* and a Health Service Provider's *Mortality Review Committee*). The Ombudsman will review all investigable deaths as well as those child deaths that are not reviewed by one of these existing death review mechanisms.

The Ombudsman can also review other notified child deaths. Under Section 16 of the *Parliamentary Commissioner Act 1971*, the Ombudsman may determine to undertake a child death review under his own motion, where a child death may not be defined as an investigable death in accordance with Section 19A(3).

In undertaking a child death review, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths. The Ombudsman may also undertake major own motion investigations arising from child death reviews (discussed later in this section).

In reviewing child deaths the Ombudsman has wide powers of investigation, including powers to obtain information relevant to the death of a child and powers to recommend improvements to public administration about ways to prevent or reduce child deaths across all agencies within the Ombudsman's jurisdiction. The Ombudsman also has powers to monitor the steps that have been taken, are proposed to be taken or have not been taken to give effect to the recommendations.

The Child Death Review Process

The Ombudsman is notified of all child deaths that occur in WA

Births, Deaths and Marriages notifies the Ombudsman of all registered child deaths

The Department of Health notifies the Ombudsman of all child deaths known to Health Service Providers

Communities notifies the Ombudsman of all child deaths notified to it by the Coroner (those deaths that are reportable to the Coroner)

The Ombudsman reconciles the data from the three notification sources to identify the individual child deaths. Each child death notification is assessed to determine:

- whether the death is an investigable death or a non-investigable death; and
- whether a review will be conducted by an existing medical death review mechanism (including the *Perinatal and infant mortality review committee* and Health Service Provider *Mortality Review Committee*).

Ombudsman conducts review

- All investigable deaths are reviewed
- All deaths that are not reported to the Coroner, and not reviewed by an existing medical death review mechanism are reviewed
- Other deaths can be reviewed

Identifying patterns and trends

- Data on all child deaths is obtained, and reconciled
- Patterns and trends are identified, analysed and reported and also provide critical information to inform the selection and undertaking of major own motion investigations

Improving public administration

The Ombudsman seeks to improve public administration to prevent or reduce child deaths, including making recommendations to prevent or reduce child deaths arising from reviews and major own motion investigations

Implementation of recommendations and monitoring improvements

The Ombudsman actively monitors the implementation of recommendations as well as ensuring those improvements to public administration are contributing over time to preventing or reducing child deaths

Analysis of Child Death Reviews

By reviewing child deaths, the Ombudsman is able to identify, record and report on a range of information and analysis, including:

- The number of child death notifications and reviews;
- The comparison of investigable deaths over time;
- Demographic information identified from child death notifications;
- Circumstances in which child deaths have occurred;
- Social and environmental factors associated with investigable child deaths;
- Analysis of children in particular age groups; and
- Patterns, trends and case studies relating to child death reviews.

Notifications and reviews

Since 1 July 2020, the Ombudsman receives information on all child deaths in Western Australia. This includes information about the circumstances of the child's death together with a summary outlining the past involvement, if any, of Communities with the child and the child's family.

The Ombudsman assesses all child death notifications received to determine if the death is, or is not, an investigable death. If the death is an investigable death, it must be reviewed. If the death is a non-investigable death, it can be reviewed. The Ombudsman also identifies if the child death is reported to the Coroner, or will be reviewed by an existing medical death review mechanism, and will review those deaths that do not fall into one of these categories. The extent of a review depends on a number of factors, including the circumstances surrounding the child's death and the level of involvement of Communities or other public authorities in the child's life. Confidentiality of the child, family members and other persons involved with the case is strictly observed.

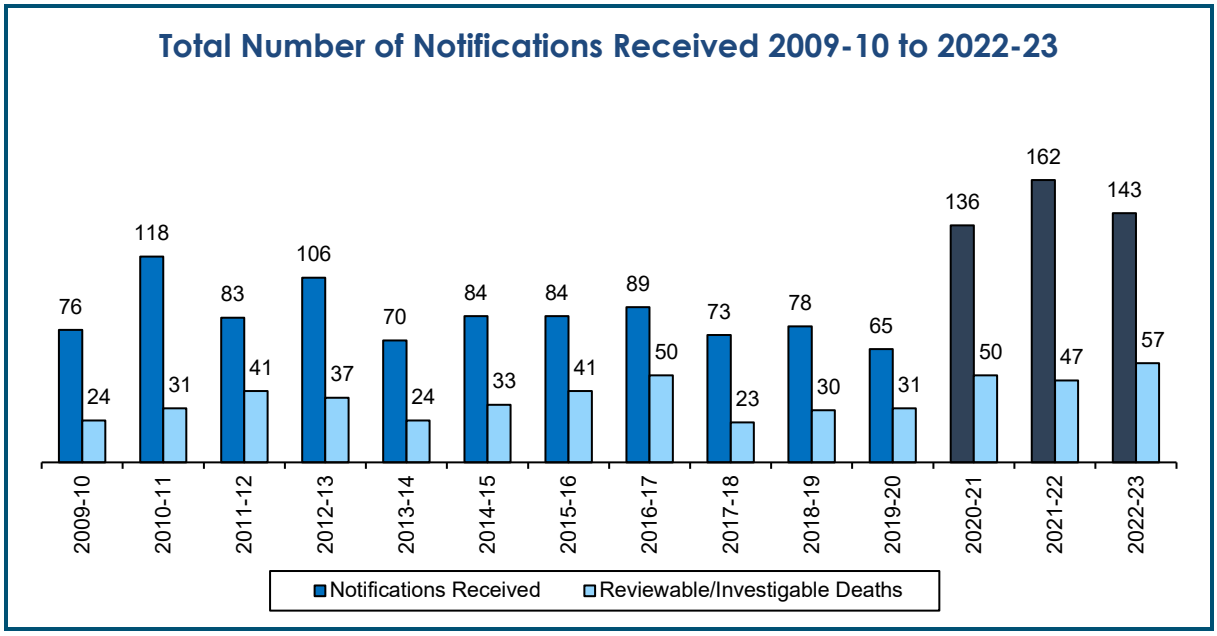
The child death review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce child deaths. The review does not set out to establish the cause of the child's death; this is properly the role of the Coroner or the certifying medical practitioner.

Number of child death notifications and reviews

Expanded data on child deaths

From 1 July 2020, the Ombudsman has received notifications of all child deaths in Western Australia, including those notified from Communities, the Department of Health, and Births, Deaths and Marriages. Accordingly, the Ombudsman is able to expand the data reported in relation to child deaths, providing an even more comprehensive understanding of child deaths in Western Australia. The data for the years 2020-21 and 2021-22, as previously reported, has also been updated in this year's annual report.

During 2022-23, there were 57 child deaths that were investigable and subject to review from a total of 143 child death notifications received.



Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Comparison of investigable deaths over time

The Ombudsman commenced the child death review function on 30 June 2009. Prior to that, child death reviews were undertaken by the CDRC with the first full year of operation of the CDRC in 2003-04.

The following table provides the number of deaths that were determined to be investigable by the Ombudsman or reviewable by the CDRC compared to all child deaths in Western Australia for the 20 years from 2003-04 to 2022-23. It is important to note that an investigable death is one which meets the legislative criteria and does not necessarily mean that the death was preventable, or that there has been any failure of the responsibilities of Communities.

Comparisons are also provided with the number of child deaths reported to the Coroner and deaths where the child or a relative of the child was known to Communities. It should be noted that children or their relatives may be known to Communities for a range of reasons.

Year	A	B	C	D
	Total WA child deaths (excluding stillbirths) (See Note 1)	Child deaths reported to the Coroner (See Note 2)	Child deaths where the child or a relative of the child was known to Communities (See Note 3)	Reviewable/ investigable child deaths (See Note 4 and Note 5)
2003-04	177	92	42	19
2004-05	212	105	52	19
2005-06	210	96	55	14
2006-07	165	84	37	17
2007-08	187	102	58	30
2008-09	167	84	48	25
2009-10	201	93	52	24
2010-11	203	118	60	31
2011-12	150	76	49	41
2012-13	193	121	62	37
2013-14	156	75	40	24
2014-15	170	93	48	33
2015-16	178	92	61	41
2016-17	181	91	60	50
2017-18	138	81	37	23
2018-19	175	81	37	30
2019-20	140	67	38	31
2020-21	139	77	46	50
2021-22	162	68	36	47
2022-23	147	87	54	57

Notes

1. The data in Column A has been provided by Births, Deaths and Marriages. Child deaths within each year are based on the date of death rather than the date of registration of the death. The CDRC included numbers based on dates of registration of child deaths in their Annual Reports in the years 2005-06 through to 2007-08 and accordingly the figures in Column A will differ from the figures included in the CDRC Annual Reports for these years because of the difference between dates of child deaths and dates of registration of child deaths. The data in Column A is subject to updating and may vary from data published in previous Annual Reports.
2. The data in Column B has been provided by the Office of the State Coroner. Reportable child deaths received by the Coroner are deaths reported to the Coroner of children under the age of 18 years pursuant to the provisions of the *Coroners Act 1996*. The data in this section is based on the number of deaths of children that were reported to the Coroner during the year.
3. 'Communities' refers to the Department of Communities from 2017-18, Department for Child Protection and Family Support for the year 2012-13 to 2016-17, Department for Child Protection for the years 2006-07 to 2011-12 and Department for Community Development (**DCD**) prior to 2006-

07. The data in Column C has been provided by Communities and is based on the date the notification was received by Communities. For 2003-04 to 2007-08 this information is the same as that included in the CDRC Annual Reports for the relevant year. In the 2005-06 to 2007-08 Annual Reports, the CDRC counted 'Child death notifications where any form of contact had previously occurred with Communities: recent, historical, significant or otherwise'. In the 2003-04 and 2004-05 Annual Reports, the CDRC counted 'Coroner notifications where the families had some form of contact with DCD'.

4. The data in Column D relates to child deaths considered reviewable by the CDRC up to 30 June 2009 or child deaths determined to be investigable by the Ombudsman from 30 June 2009. It is important to note that reviewable deaths and investigable deaths are not the same, however, they are similar in effect. The definition of reviewable death is contained in the Annual Reports of the CDRC. The term investigable death has the meaning given to it under section 19A(3) of the *Parliamentary Commissioner Act 1971*.

5. The number of investigable child deaths shown in a year may vary, by a small amount, from the number shown in previous annual reports for that year. This occurs because, after the end of the reporting period, further information may become available that requires a reassessment of whether or not the death is an investigable death.

Demographic information identified from child death reviews

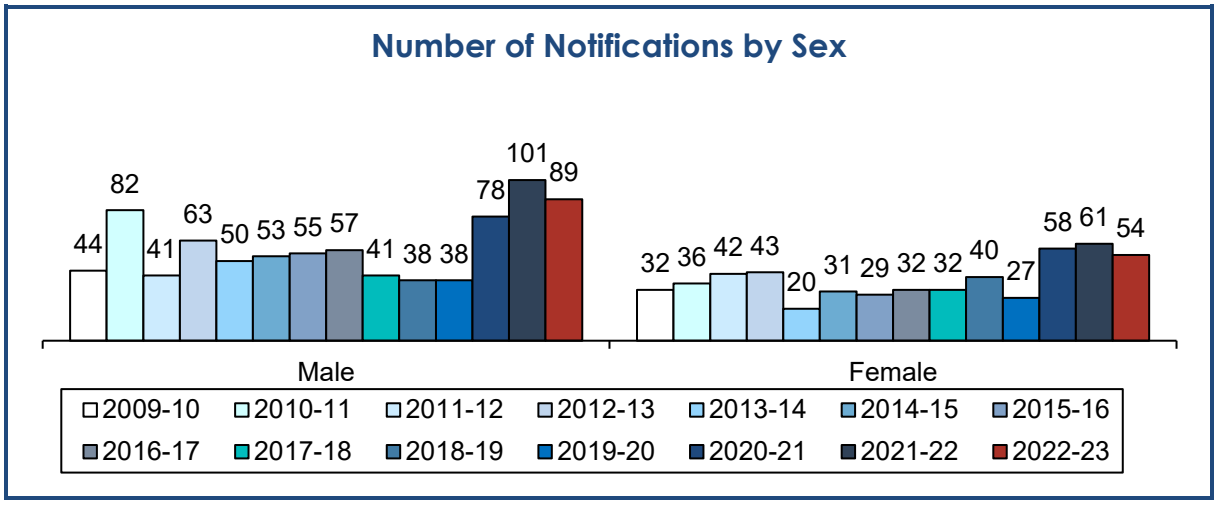
Information is obtained on a range of characteristics of the children who have died including sex, Aboriginal status, age groups and residence in the metropolitan or regional areas. A comparison between investigable and non-investigable deaths can give insight into factors that may be able to be affected by Communities in order to prevent or reduce deaths.

The following charts show:

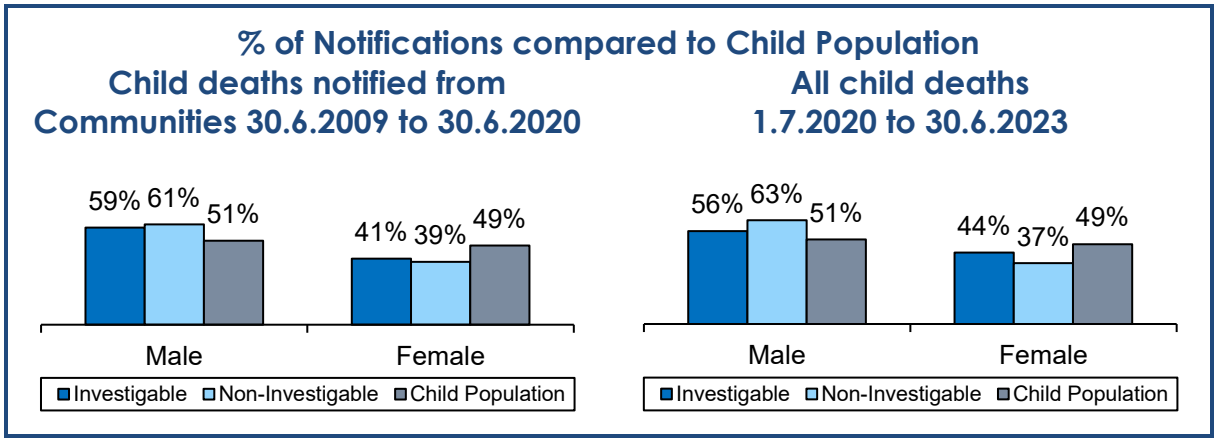
- The number of children in each group for each year from 2009-10 to 2022-23; and
- For the period from 30 June 2009 to 30 June 2023, the percentage of children in each group for both investigable deaths and non-investigable deaths, compared to the child population in Western Australia.

Males and females

Information is collated on a child's sex (male or female) as identified in agency documentation provided to this Office. As shown in the following charts, considering all 14 years, male children are over-represented compared to the population for both investigable and non-investigable deaths.



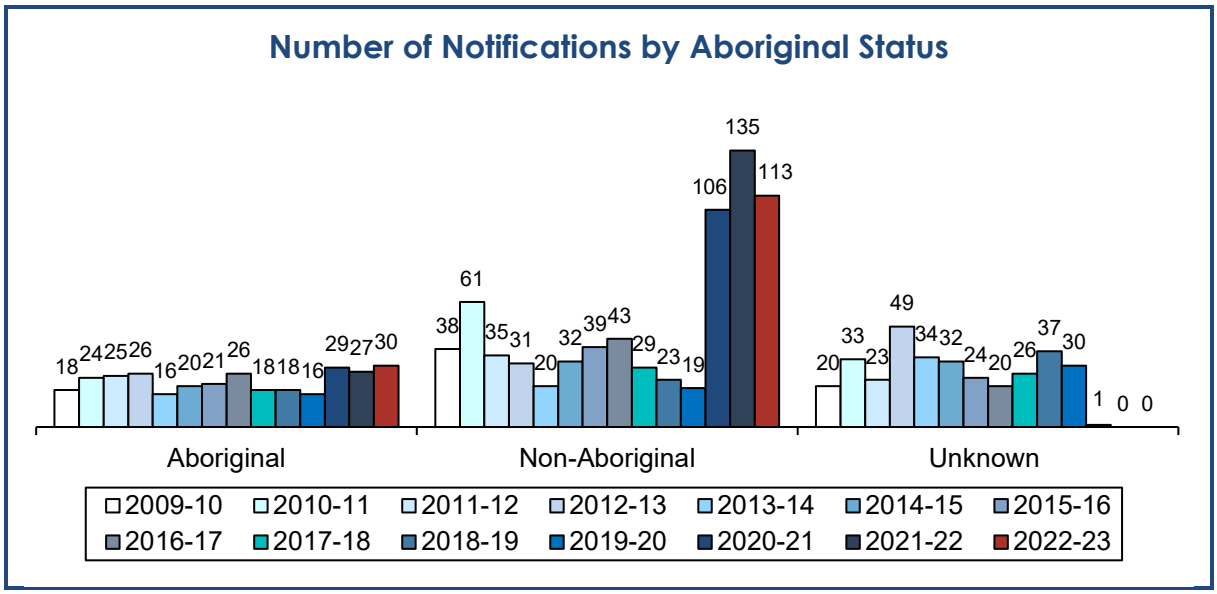
Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



Further analysis of the data shows that, considering all 14 years, male children are over-represented for all age groups, but particularly for children under the age of one, children aged between six and 12 years, and children aged 13 to 17 years.

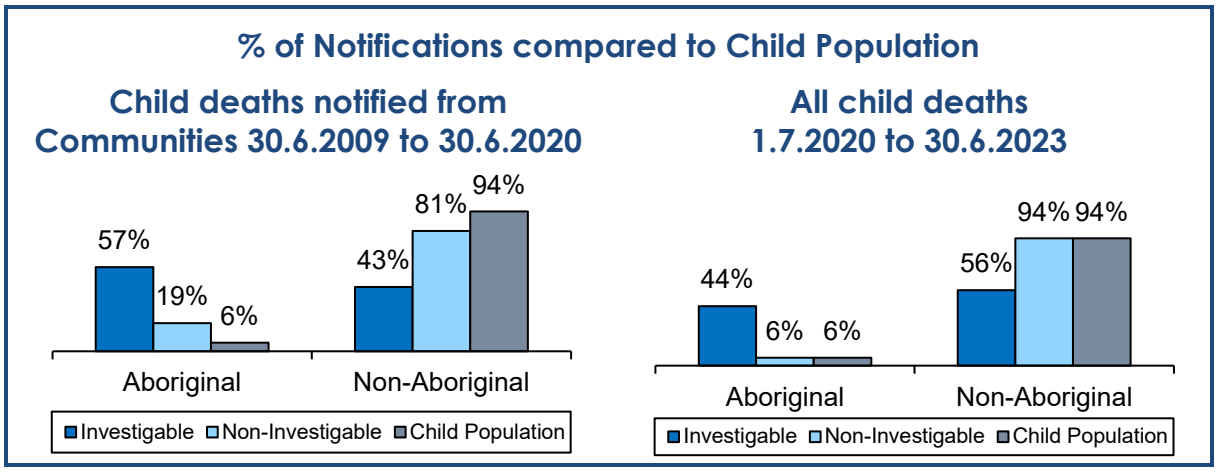
Aboriginal status

Information on Aboriginal status is collated where a child, or one/both of their parents, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. As shown in the following charts, Aboriginal children are over-represented compared to the population in all deaths and more so for investigable deaths.



Note 1: The "Aboriginal" category in the charts includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander. Use of the term "Aboriginal" reflects the dominant heritage of First Nations people in Western Australia.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



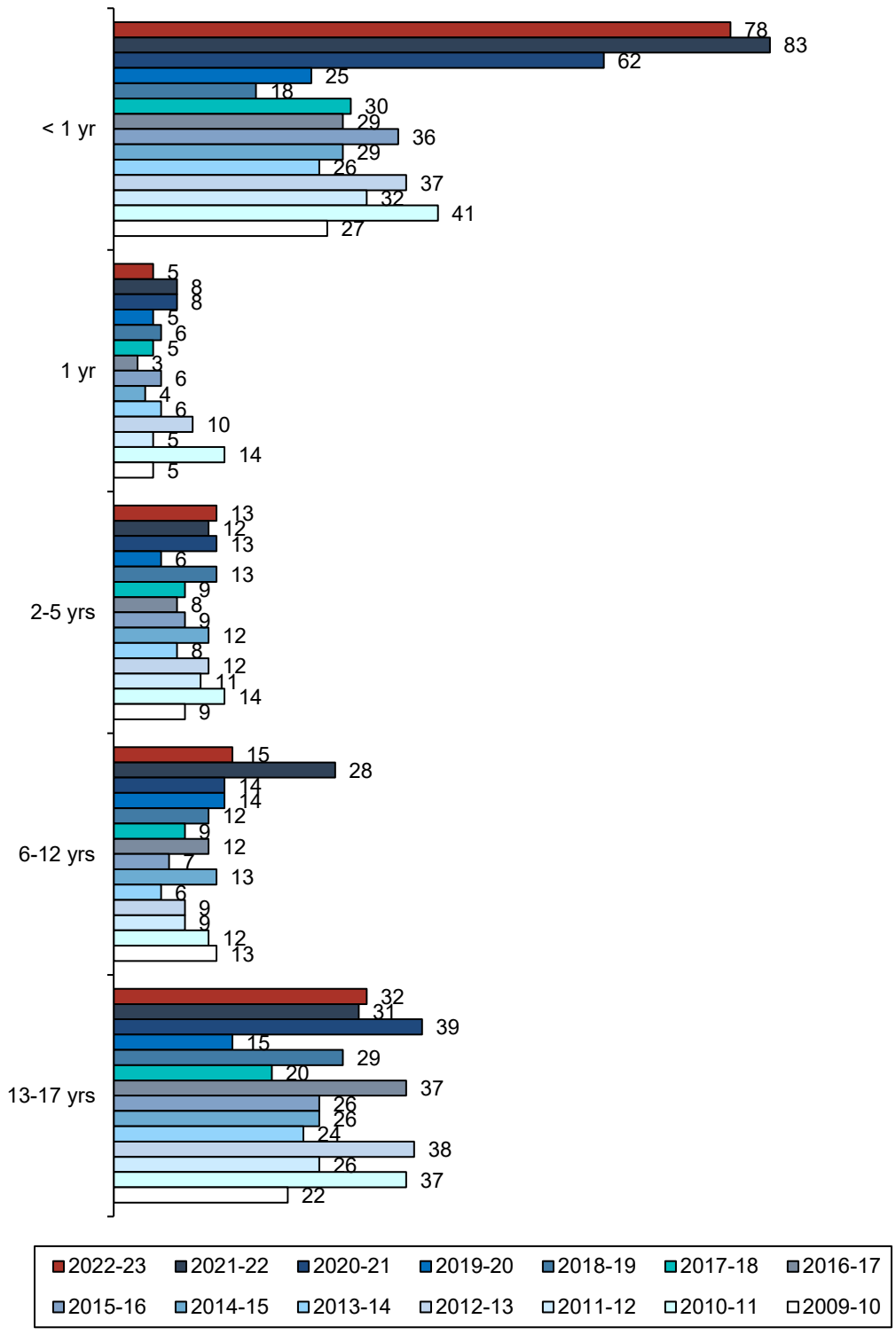
Note: Percentages for each group are based on the percentage of children whose Aboriginal status is known. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the Aboriginal status of the child.

Further analysis of the data shows that Aboriginal children are more likely than non-Aboriginal children to be under the age of one and living in regional and remote locations.

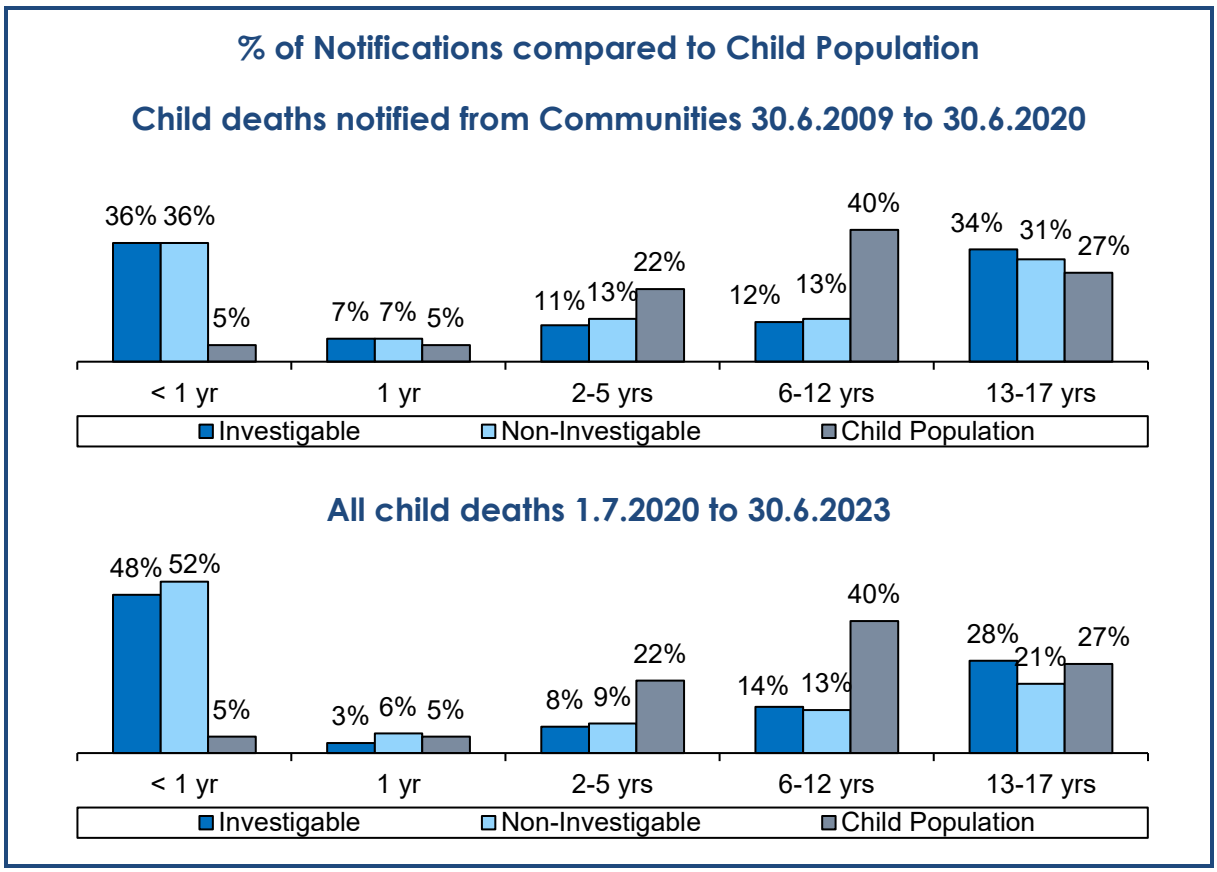
Age groups

As shown in the following charts, children under one year, children aged one year, and children aged between 13 and 17 are over-represented compared to the child population as a whole for both investigable and non-investigable deaths.

Number of Notifications by Age of Child



Note: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

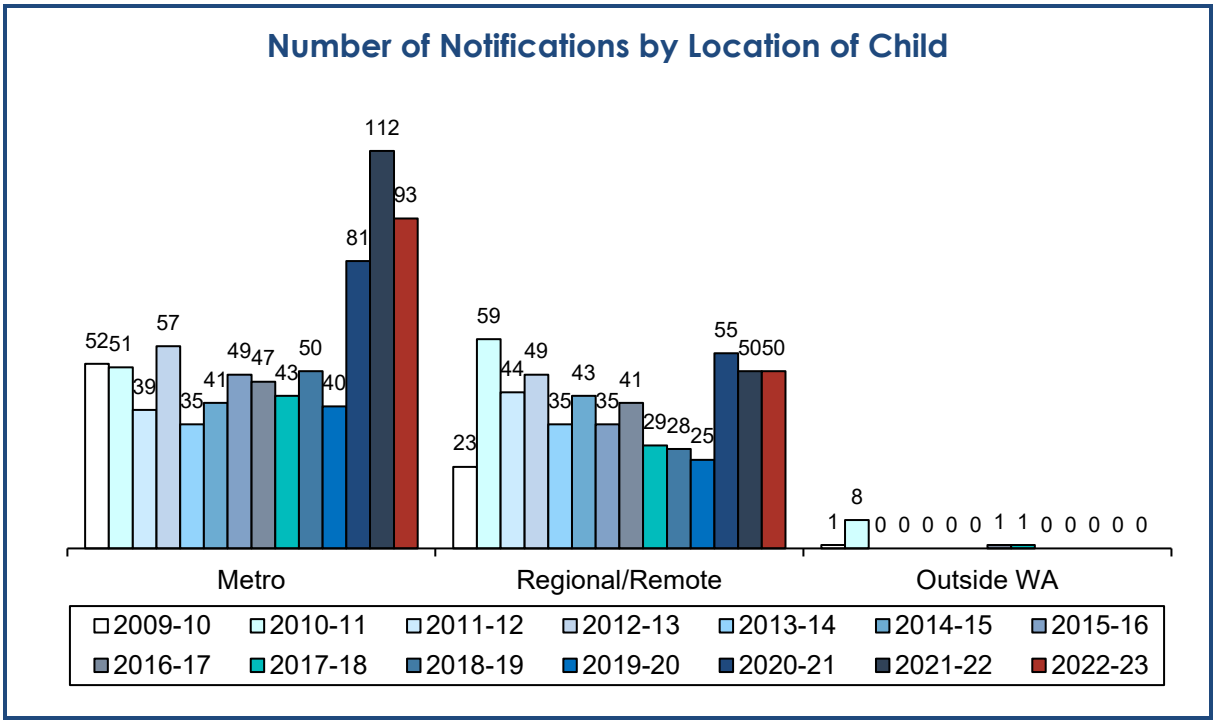


Note: Percentages may not add to 100 per cent due to rounding.

A more detailed analysis by age group is provided later in this section.

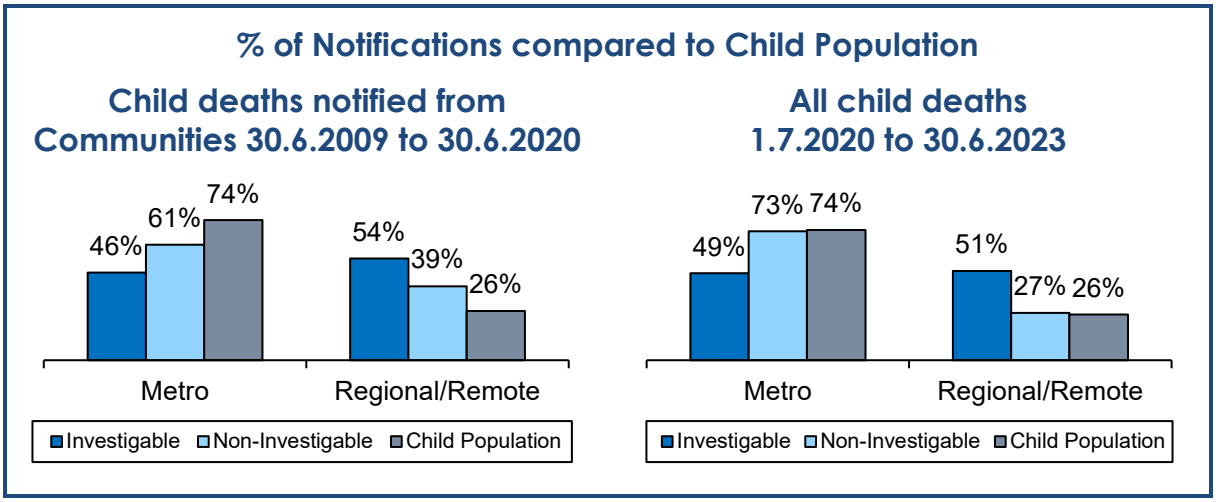
Location of residence

As shown in the following charts, children in regional locations are over-represented compared to the child population as a whole, and more so for investigable deaths.



Note 1: Outside WA includes children whose residence is not in Western Australia, but the child died in Western Australia. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the place of residence of the child.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



Further analysis of the data shows that 73% of Aboriginal children who died were living in regional or remote locations when they died. Most non-Aboriginal children who died lived in the metropolitan area but the proportion of non-Aboriginal children who died in regional areas (31%) is higher than would be expected based on the child population.

Circumstances in which child deaths have occurred

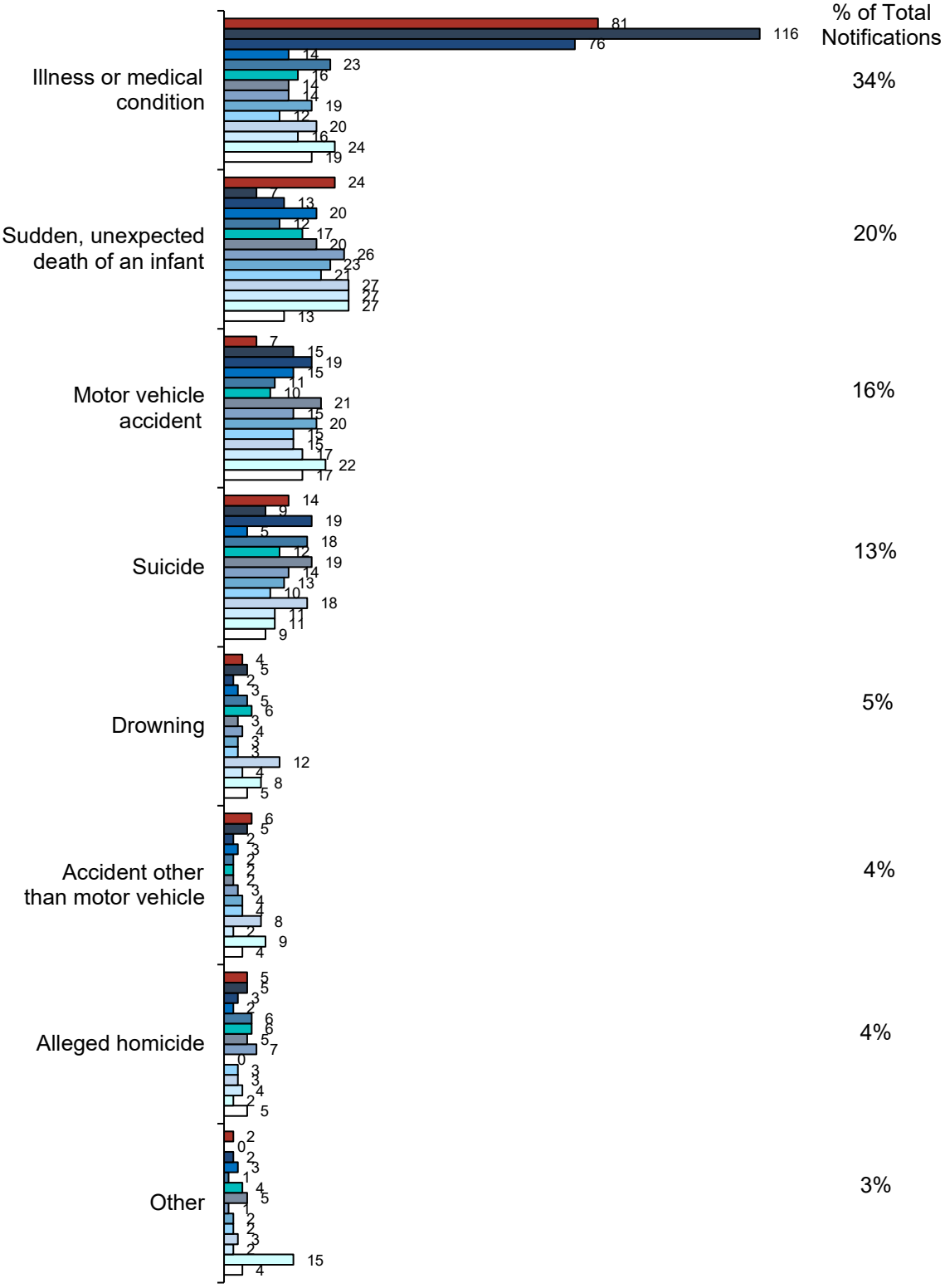
The child death notification received by the Ombudsman includes general information on the circumstances of death. This is an initial indication of how the child may have died but is not the cause of death, which can only be determined by the Coroner. The Ombudsman's review of the child death will normally be finalised prior to the Coroner's determination of cause of death.

The circumstances of death are categorised by the Ombudsman as:

- Sudden, unexpected death of an infant – that is, infant deaths in which the likely cause of death cannot be explained immediately;
- Motor vehicle accident – the child may be a pedestrian, driver or passenger;
- Illness or medical condition;
- Suicide;
- Drowning;
- Accident other than motor vehicle – this includes accidents such as house fires, electrocution and falls;
- Alleged homicide; and
- Other.

The following chart shows the circumstances of notified child deaths for the period 30 June 2009 to 30 June 2023.

Circumstances of Child Deaths



Note 1: In 2010-11, the 'Other' category includes eight children who died in the SIEV (Suspected Illegal Entry Vessel) 221 boat tragedy off the coast of Christmas Island in December 2010.

Note 2: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Note 3: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Note 4: Percentages may not add to 100 per cent due to rounding.

The main circumstances of death for the 1,367 child death notifications received in the 14 years from 30 June 2009 to 30 June 2023 are illness or medical condition (34%), sudden, unexpected deaths of infants (20%) and motor vehicle accidents (16%).

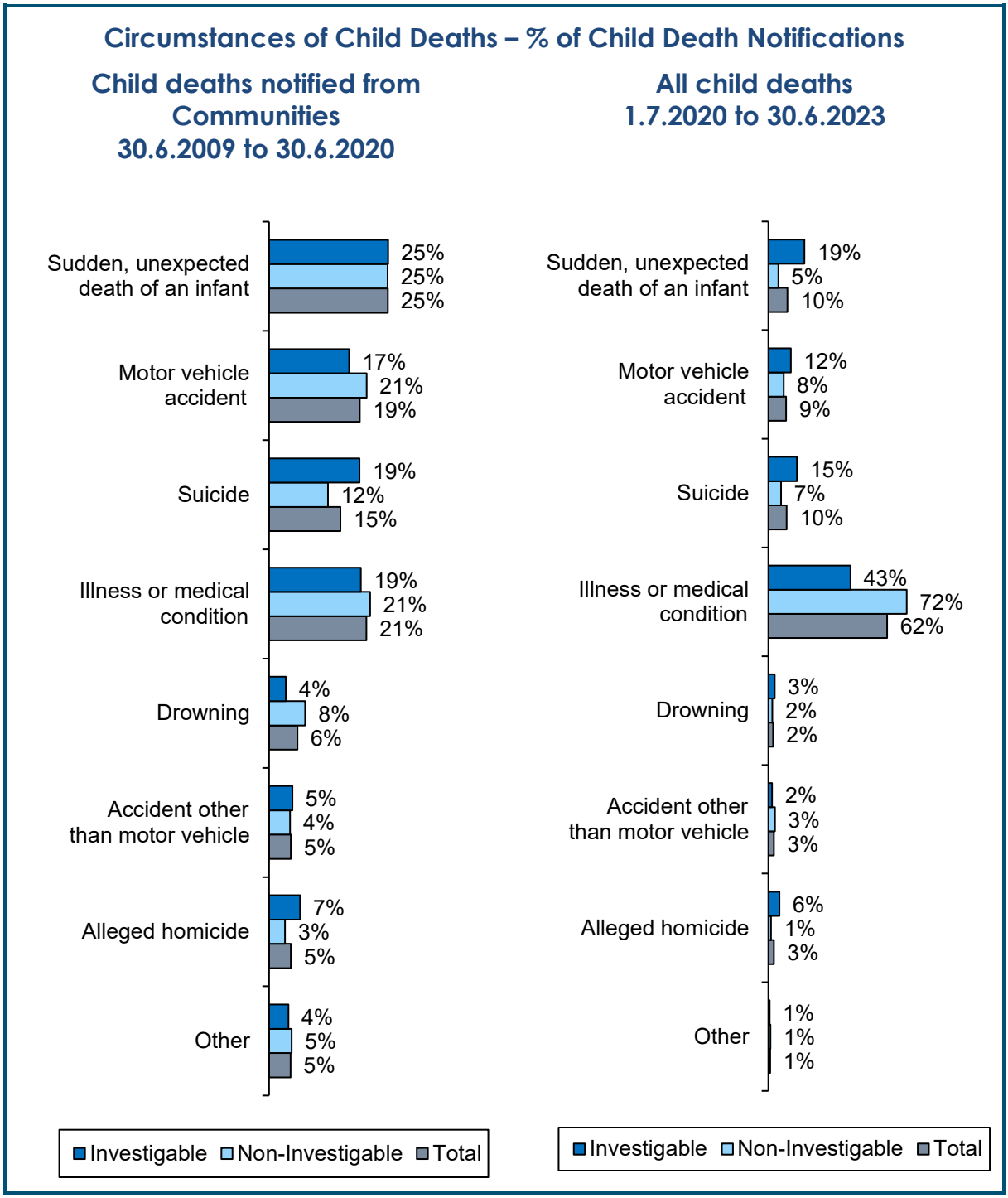
For the period 30 June 2009 to 30 June 2020, when the Ombudsman received notifications from Communities about child deaths reported to the Coroner, the main circumstances of death were:

- Sudden, unexpected deaths of infants, representing 25% of the total child death notifications over this period (17% of the child death notifications received in 2009-10, 23% in 2010-11, 33% in 2011-12, 25% in 2012-13, 30% in 2013-14, 27% in 2014-15, 31% in 2015-16, 22% in 2016-17, 23% in 2017-18, 15% in 2018-19, and 31% in 2019-20); and
- Motor vehicle accidents, representing 25% of the total child death notifications over this period (22% of the child death notifications received in 2009-10, 19% in 2010-11, 20% in 2011-12, 14% in 2012-13, 21% in 2013-14, 24% in 2014-15, 18% in 2015-16, 24% in 2016-17, 14% in 2017-18, 14% in 2018-19, and 23% in 2019-20.

For the period 1 July 2020 to 30 June 2023, when the Ombudsman received notifications of all child deaths in Western Australia, the main circumstances of death were:

- Illness or medical condition, representing 62% of the total child death notifications over this period (56% of child death notifications received in 2020-21, 72% in 2021-22 and 57% in 2022-23); and
- Sudden, unexpected deaths of infants, representing 10% of the total child death notifications over this period (10% of child death notifications received in 2020-21, 4% in 2021-22 and 17% in 2022-23).

The following chart provides a breakdown of the circumstances of death for child death notifications for investigable and non-investigable deaths.



Note: Percentages may not add to 100 per cent due to rounding.

Considering all 14 years, there are three areas where the circumstance of death shows a higher proportion for investigable deaths than for deaths that are not investigable. These are:

- Suicide;
- Alleged homicide; and
- Sudden, unexpected death of an infant.

Longer term trends in the circumstances of death

The CDRC also collated information on child deaths, using similar definitions, for the deaths it reviewed. The following tables show the trends over time in the circumstances of death. It should be noted that the Ombudsman's data shows the information for all notifications received, including deaths that are not investigable, while the data from the CDRC relates only to completed reviews.

Ombudsman from 30 June 2009

The figures on the circumstances of death from 2009-10 relate to all notifications received by the Ombudsman during the year including cases that are not investigable and are not known to Communities. These figures are much larger than previous years as the CDRC only reported on the circumstances of death for the cases that were reviewable and that were finalised during the financial year.

The figures from 2020-21 relate to all child deaths in Western Australia received by the Ombudsman during the year, while prior to this, the Ombudsman received deaths notified by Communities from deaths reported to the Coroner only. Therefore, the figures for certain circumstances of death, such as illness, medical condition and sudden, unexpected death of an infant are larger than earlier years, as these deaths can also be notified to the Ombudsman from sources other than the Coroner.

Year	Accident Other Than Motor Vehicle	Motor Vehicle Accident	Illness or Medical Condition	Asphyxiation /Suffocation	Alleged Homicide	Drowning	SUDI *	Suicide	Other
2009-10	4	17	7		5	5	25	9	4
2010-11	9	22	17		2	8	34	11	15
2011-12	2	17	12		4	4	31	11	2
2012-13	8	15	15		3	12	32	18	3
2013-14	4	15	9		3	3	24	10	2
2014-15	4	20	14		0	3	28	13	2
2015-16	3	15	11		7	4	29	14	1
2016-17	2	21	9		5	3	25	19	5
2017-18	2	10	6		6	6	27	12	4
2018-19	2	11	19		6	5	16	18	1
2019-20	3	15	10		2	3	24	5	3
2020-21	2	19	30		3	2	59	19	2
2021-22	5	15	41		5	5	82	9	0
2022-23	6	7	81		5	4	24	14	2

* Sudden, unexpected death of an infant – includes Sudden Infant Death Syndrome

Note 1: The data for the Ombudsman is based on the notifications received by the Ombudsman during the year. The types of circumstances are as used in the Ombudsman's Annual Reports. Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available on the circumstances in which the child died.

Note 2: The data from 2020-21 onwards includes all child deaths in Western Australia that were notified to the Ombudsman during the year. This includes deaths notified from Communities, the Department of Health and Births, Deaths and Marriages. Prior to this, the Ombudsman only received and reported deaths notified from Communities of deaths reported to the Coroner.

Social and environmental factors associated with investigable child deaths

A number of social and environmental factors affecting the child or their family may impact on the wellbeing of the child, such as:

- Family and domestic violence;
- Drug or substance use;
- Alcohol use;
- Parenting;
- Homelessness; and
- Parental mental health issues.

Reviews of investigable deaths often highlight the impact of these factors on the circumstances leading up to the child's death and, where this occurs, these factors are recorded to enable an analysis of patterns and trends to assist in considering ways to prevent or reduce future deaths.

It is important to note that the existence of these factors is associative. They do not necessarily mean that the removal of this factor would have prevented the death of a child or that the existence of the factor necessarily represents a failure by Communities or another public authority.

The following table shows the percentage of investigable child death reviews associated with particular social and environmental factors for the period 30 June 2009 to 30 June 2023.

Social or Environmental Factor	% of Finalised Reviews from 30.6.2009 to 30.6.2023
Family and domestic violence	74%
Parenting	64%
Drug or substance use	48%
Alcohol use	44%
Parental mental health issues	30%
Homelessness	23%

One of the features of the investigable deaths reviewed is the co-existence of a number of these social and environmental factors. The following observations can be made:

- Where family and domestic violence was present:
  - Parenting was a co-existing factor in over two-thirds of the cases;
  - Alcohol use was a co-existing factor in over half of the cases;
  - Drug or substance use was a co-existing factor in over half of the cases;
  - Homelessness was a co-existing factor in over a quarter of the cases; and

- Parental mental health issues were a co-existing factor in over a third of the cases.

- Where alcohol use was present:
  - Parenting was a co-existing factor in over three quarters of the cases;
  - Family and domestic violence was a co-existing factor in nearly nine in 10 cases;
  - Drug or substance use was a co-existing factor in over two thirds of the cases; and
  - Homelessness was a co-existing factor in over a third of the cases.

Reasons for contact with Communities

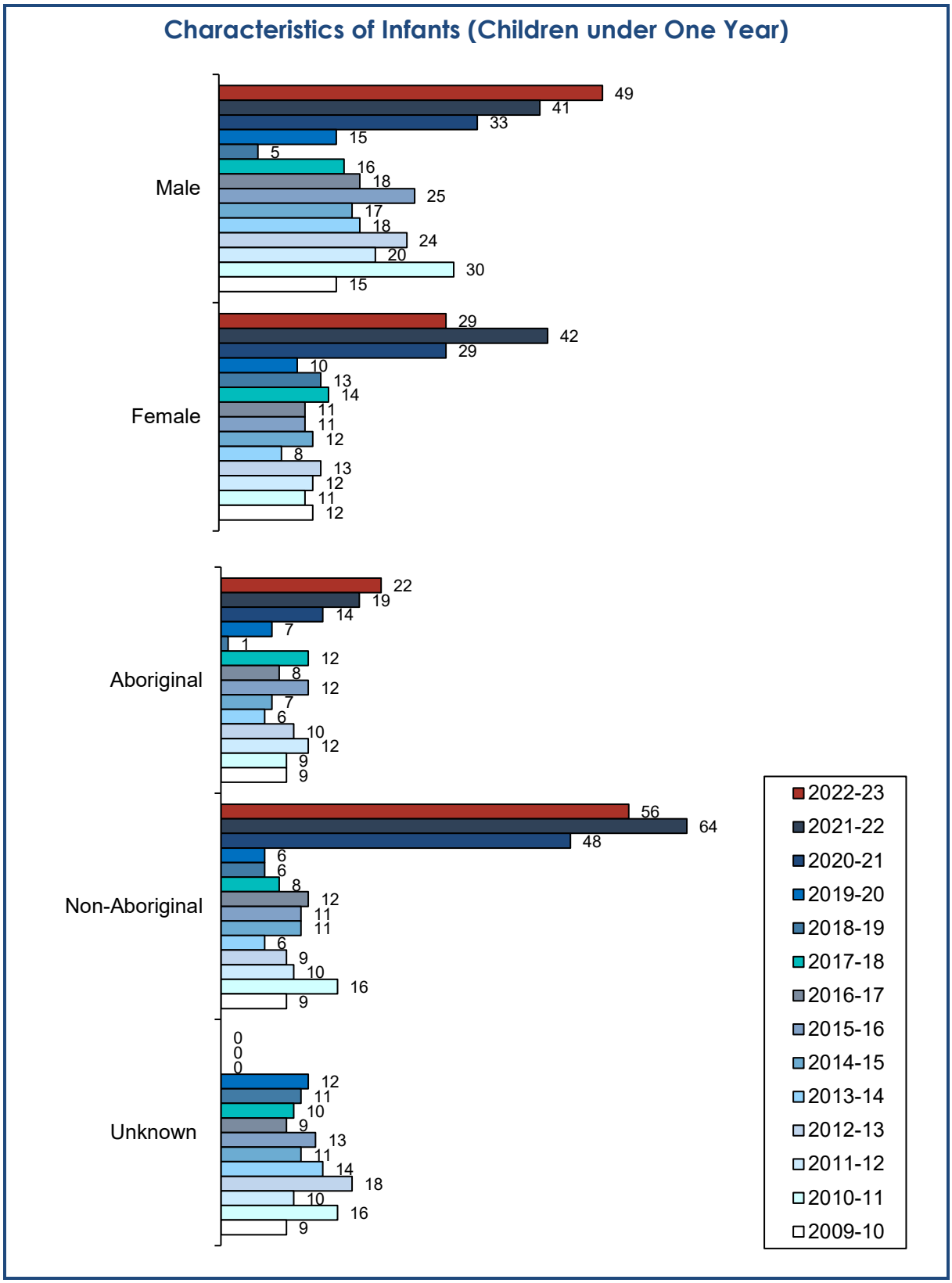
In child deaths notified to the Ombudsman in 2022-23, the majority of children who were known to Communities were known because of contact relating to concerns for a child's wellbeing or for family and domestic violence. Other reasons included financial problems, parental support, and homelessness.

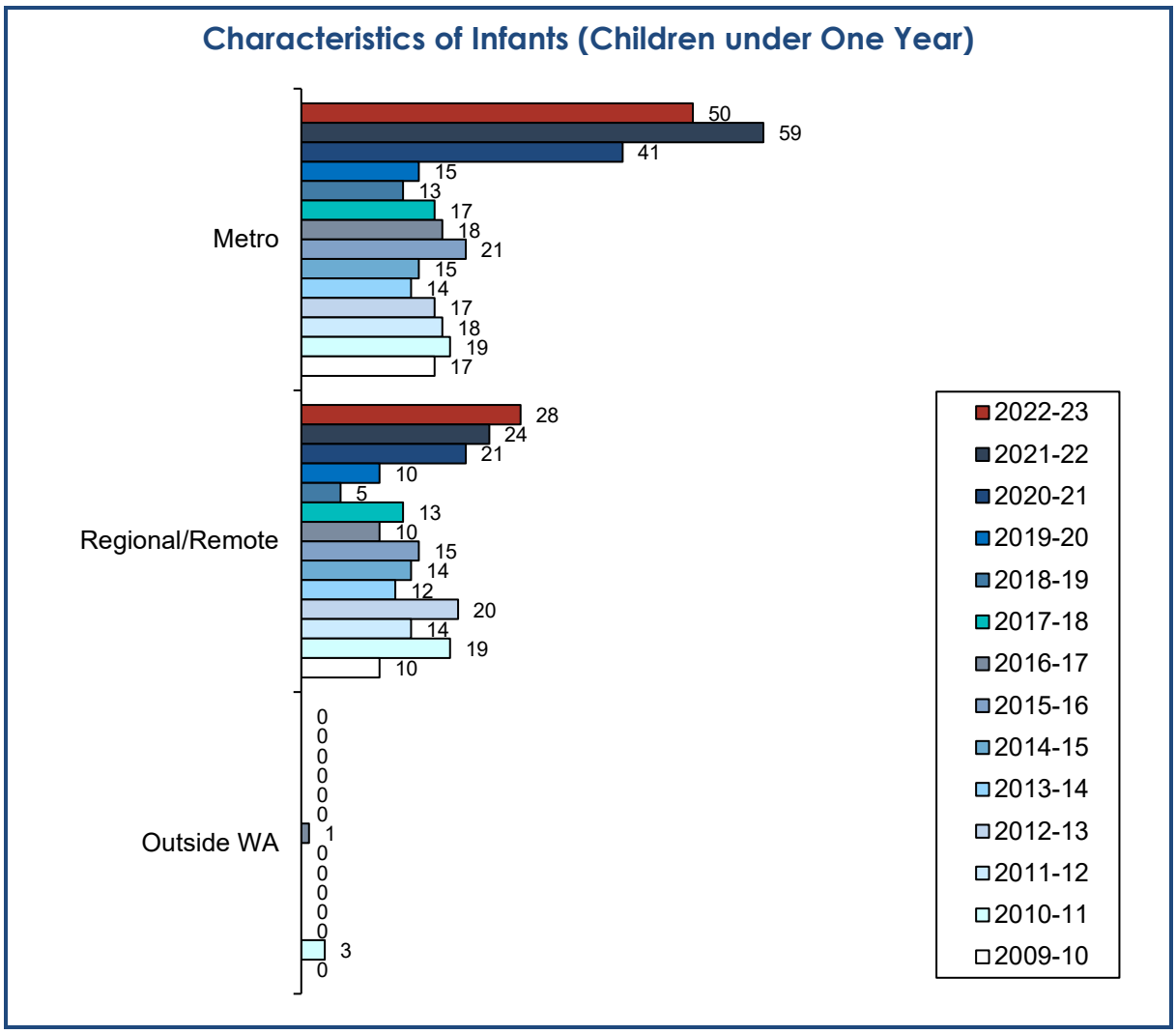
Analysis of children in particular age groups

In examining the child death notifications by their age groups, the Office is able to identify patterns that appear to be linked to childhood developmental phases and associated care needs. This age-related focus has enabled the Office to identify particular characteristics and circumstances of death that have a high incidence in each age group, and refine the reviews to examine areas where improvements to public administration may prevent or reduce these child deaths. The following section identifies four groupings of children: under one year (**infants**); children aged 1 to 5; children aged 6 to 12; and children aged 13 to 17, and demonstrates the learning and outcomes from this age-related focus.

Deaths of infants

Of the 1,367 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 553 (40%) related to deaths of infants. The characteristics of infants who died are shown in the following chart.





Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

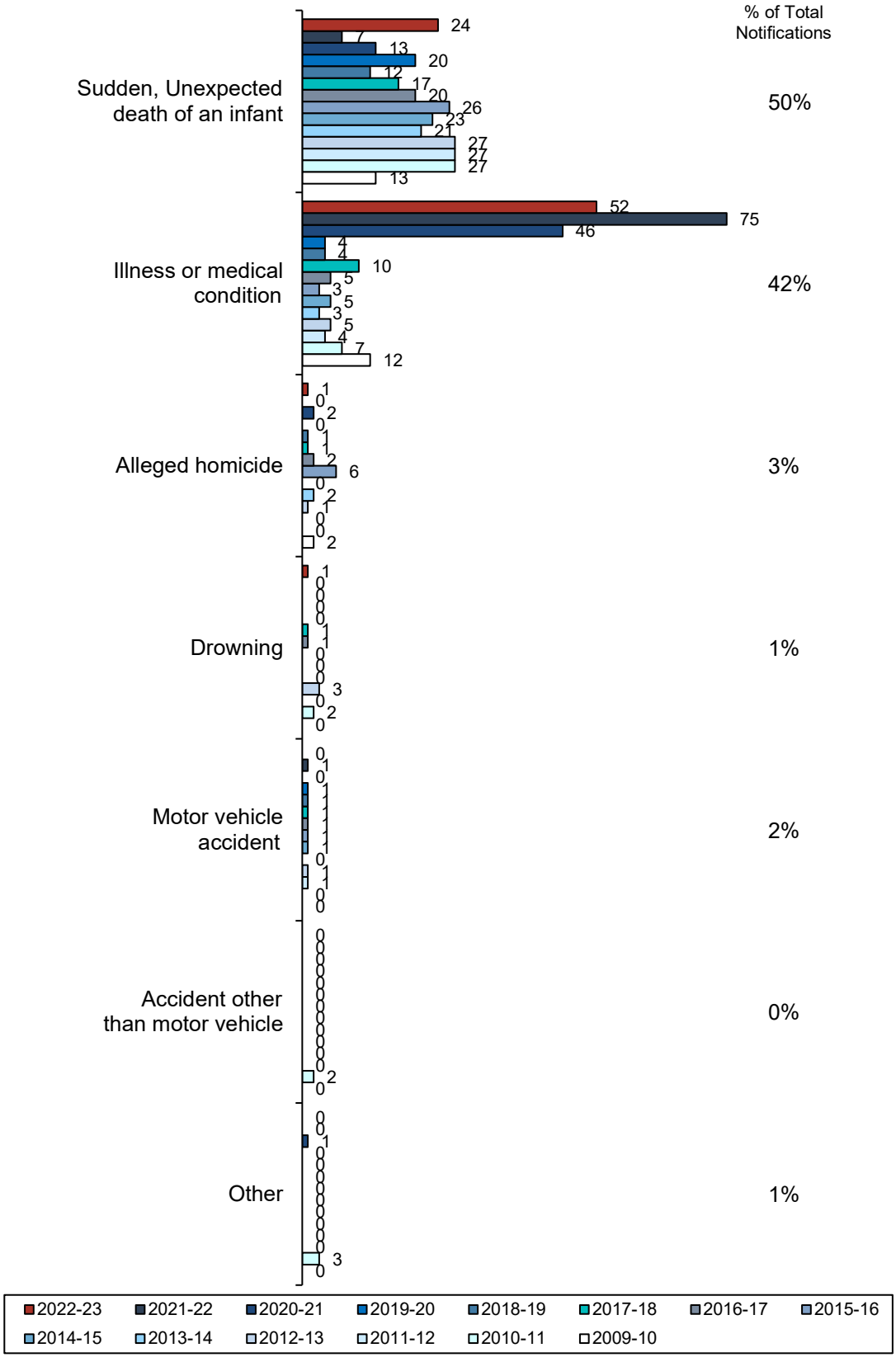
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these infant deaths, there was an over-representation compared to the child population for:

- Males – 60% of investigable infant deaths and 58% of non-investigable infant deaths were male compared to 51% in the child population;
- Aboriginal children – 63% of investigable deaths and 16% of non-investigable deaths were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 54% of investigable infant deaths and 30% of non-investigable deaths of infants, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

An examination of the patterns and trends of the circumstances of infant deaths showed that of the 553 infant deaths, 277 (50%) were categorised as sudden, unexpected deaths of an infant and 81% of these (224) appear to have occurred while the infant had been placed for sleep. There were also 42% of infant deaths (235) in circumstances of illness or medical condition, however the majority of these (173) were notified to the Ombudsman under the expanded jurisdiction from 1 July 2023. There were a small number of other deaths as shown in the following charts.

Circumstances of Infant Deaths (Children under One Year)



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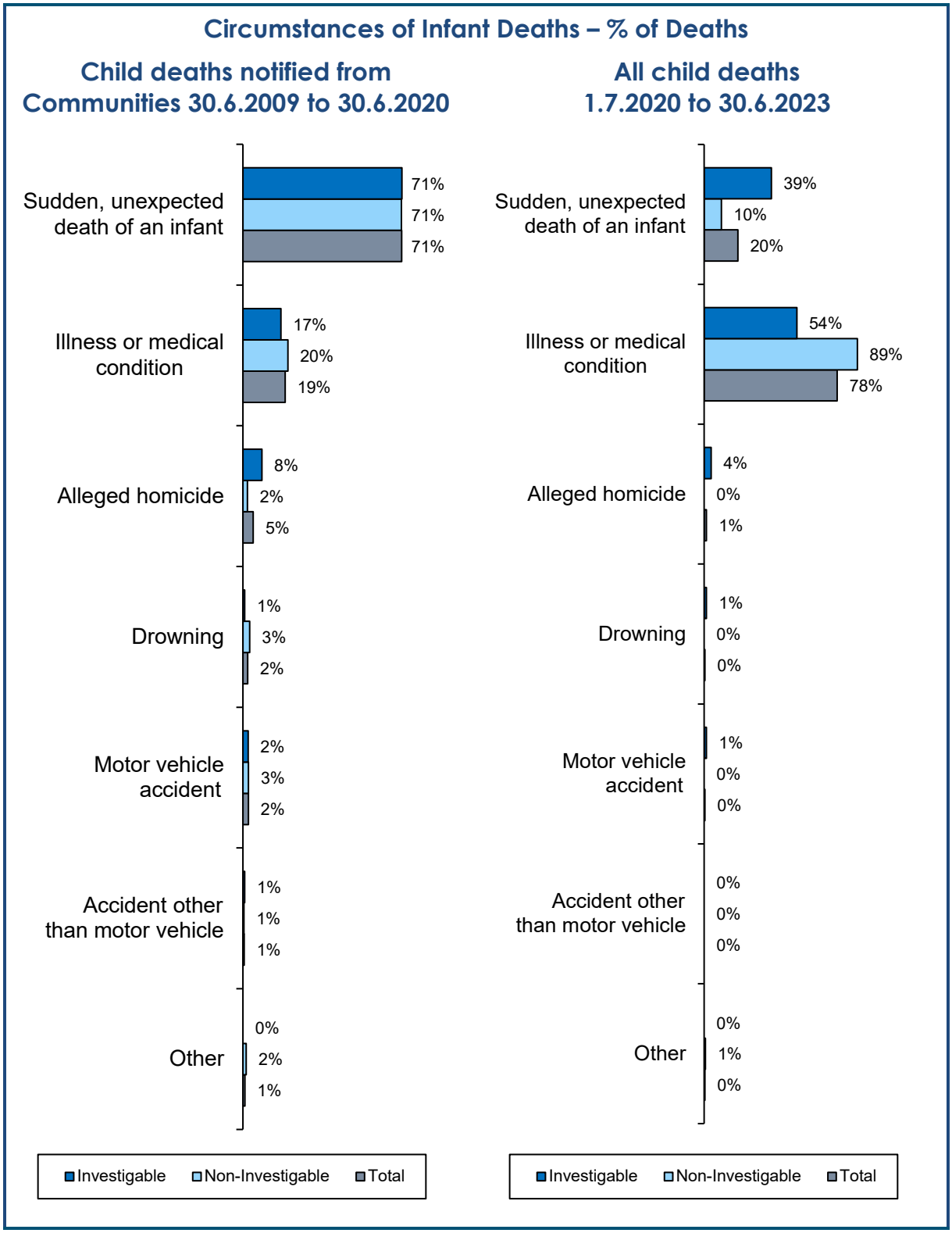


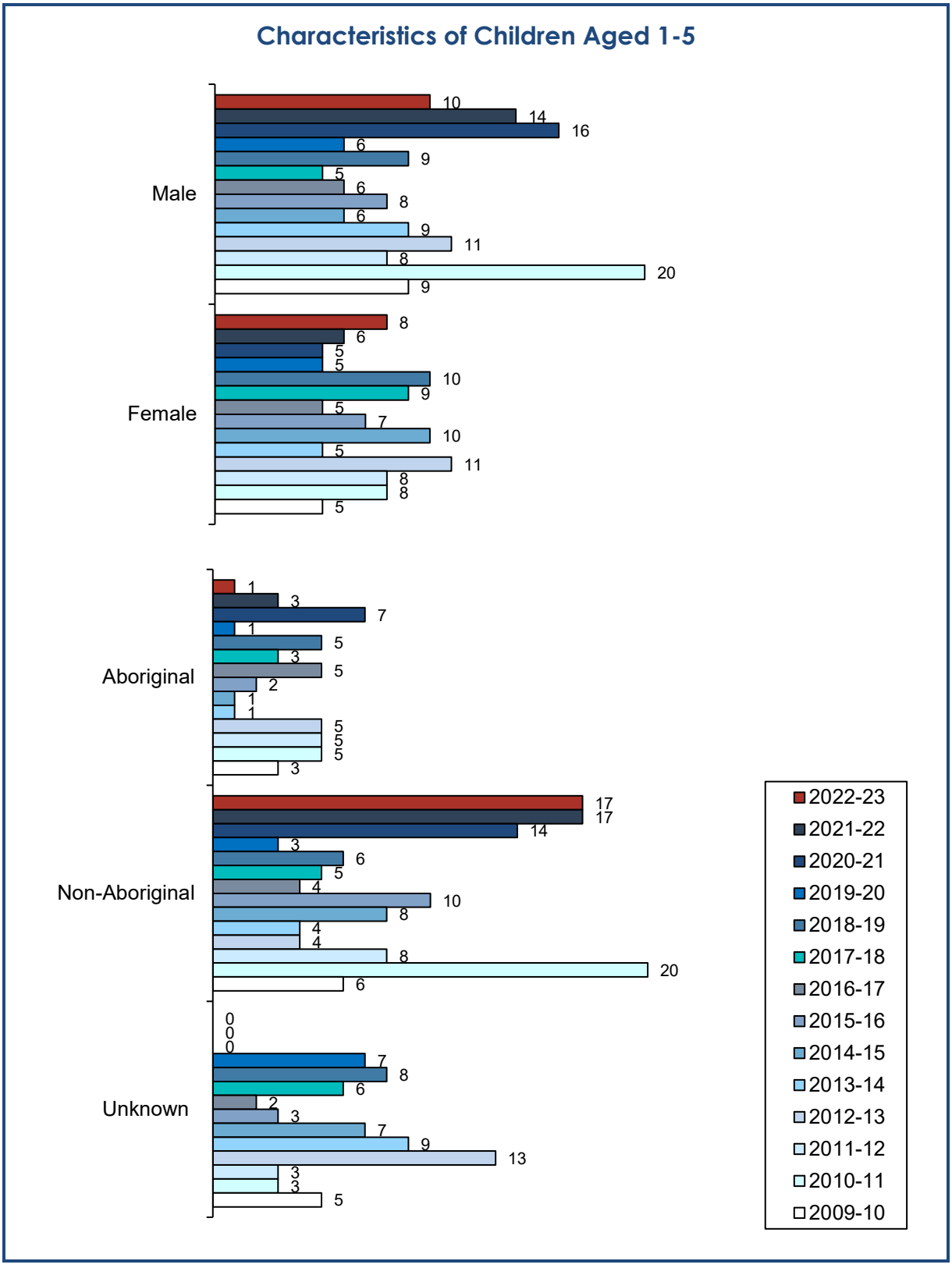
Note: Percentages may not add to 100 per cent due to rounding.

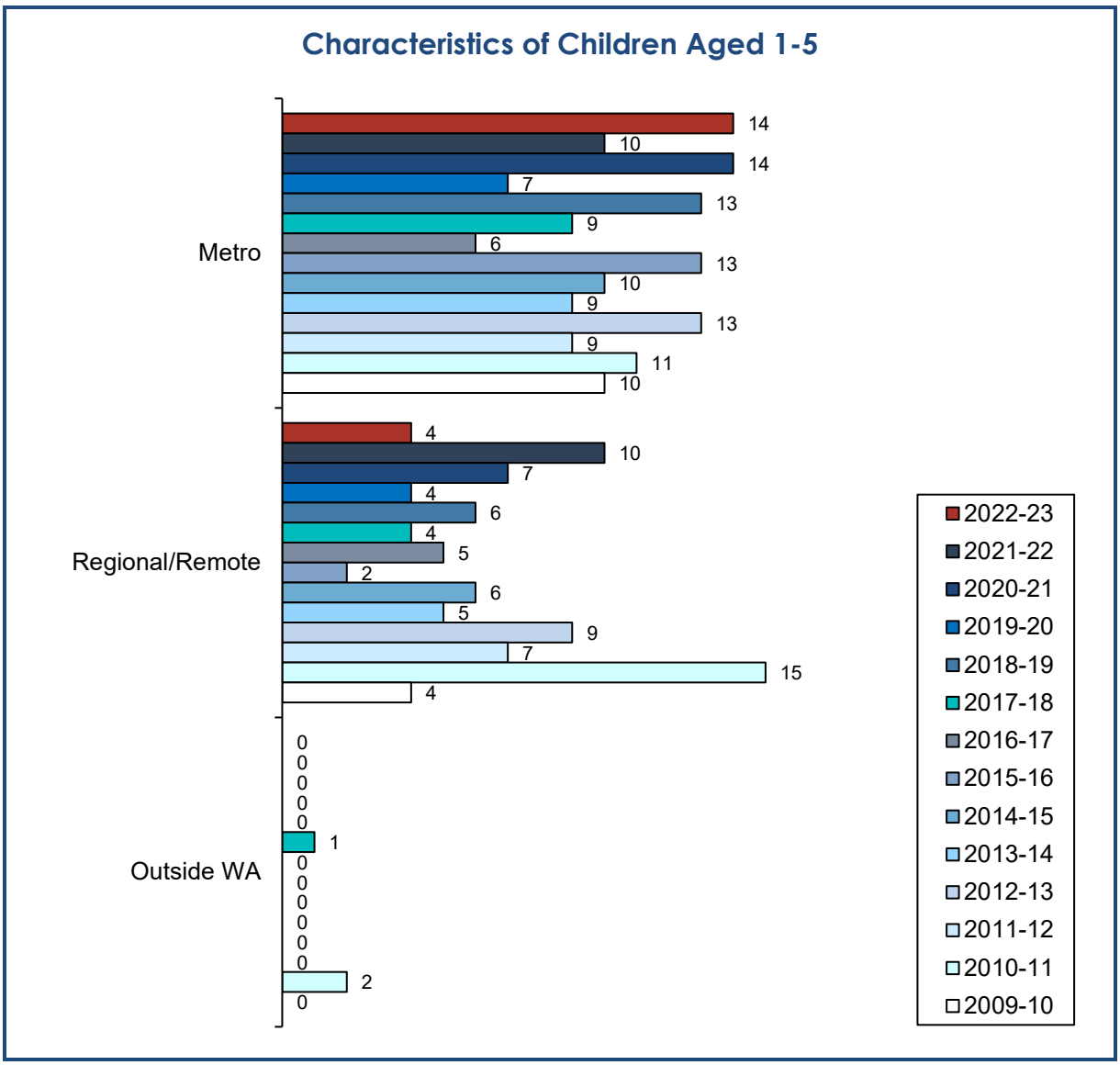
Two hundred and five deaths of infants were determined to be investigable deaths.

Deaths of children aged 1 to 5 years

Of the 1,367 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 239 (17%) related to children aged from 1 to 5 years.

The characteristics of children aged 1 to 5 are shown in the following chart.





Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

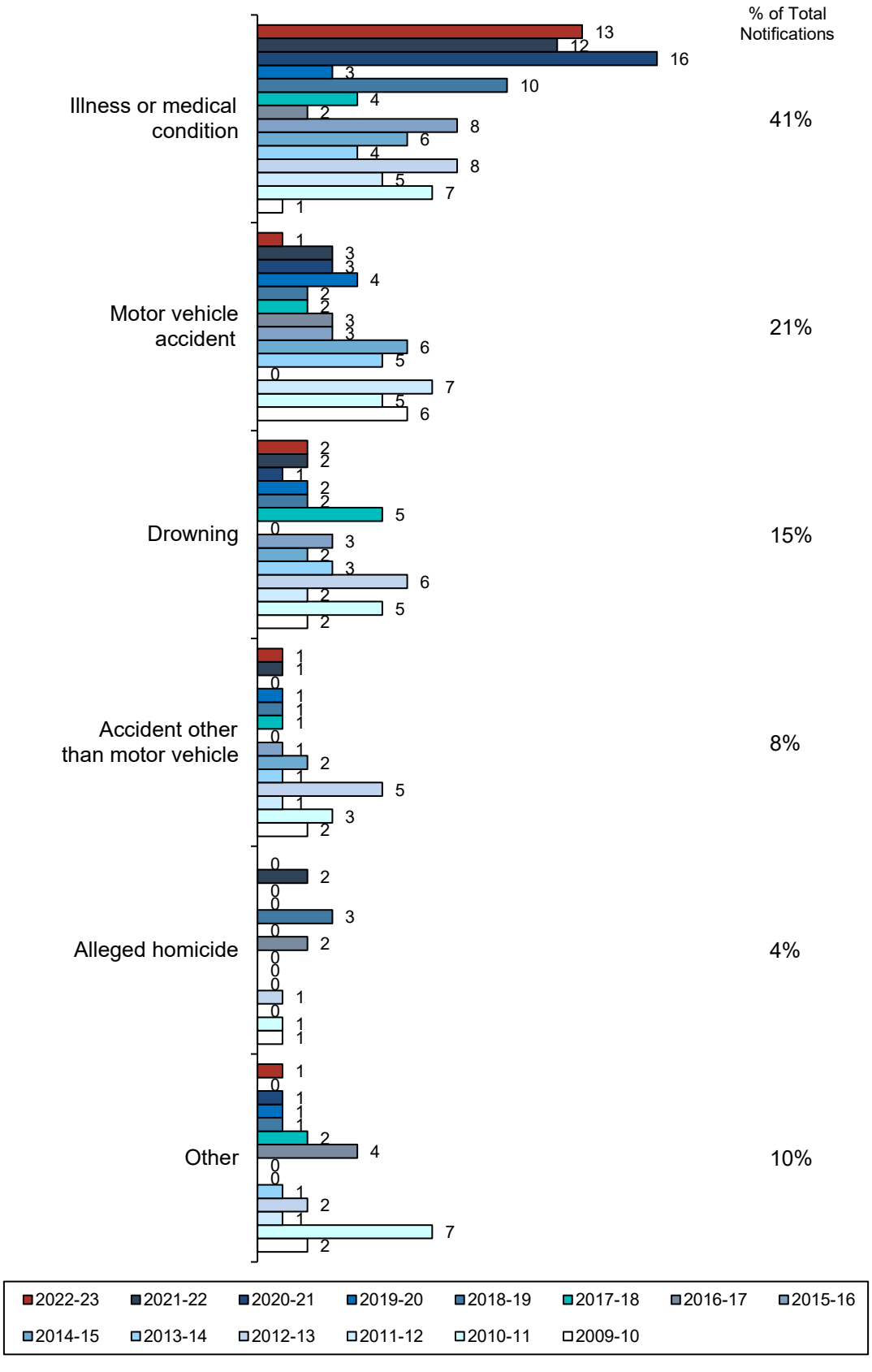
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 55% of investigable deaths and 58% of non-investigable deaths of children aged 1 to 5 were male compared to 51% in the child population;
- Aboriginal children – 49% of investigable deaths and 12% of non-investigable deaths of children aged 1 to 5 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 45% of investigable deaths and 33% of non-investigable deaths of children aged 1 to 5, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

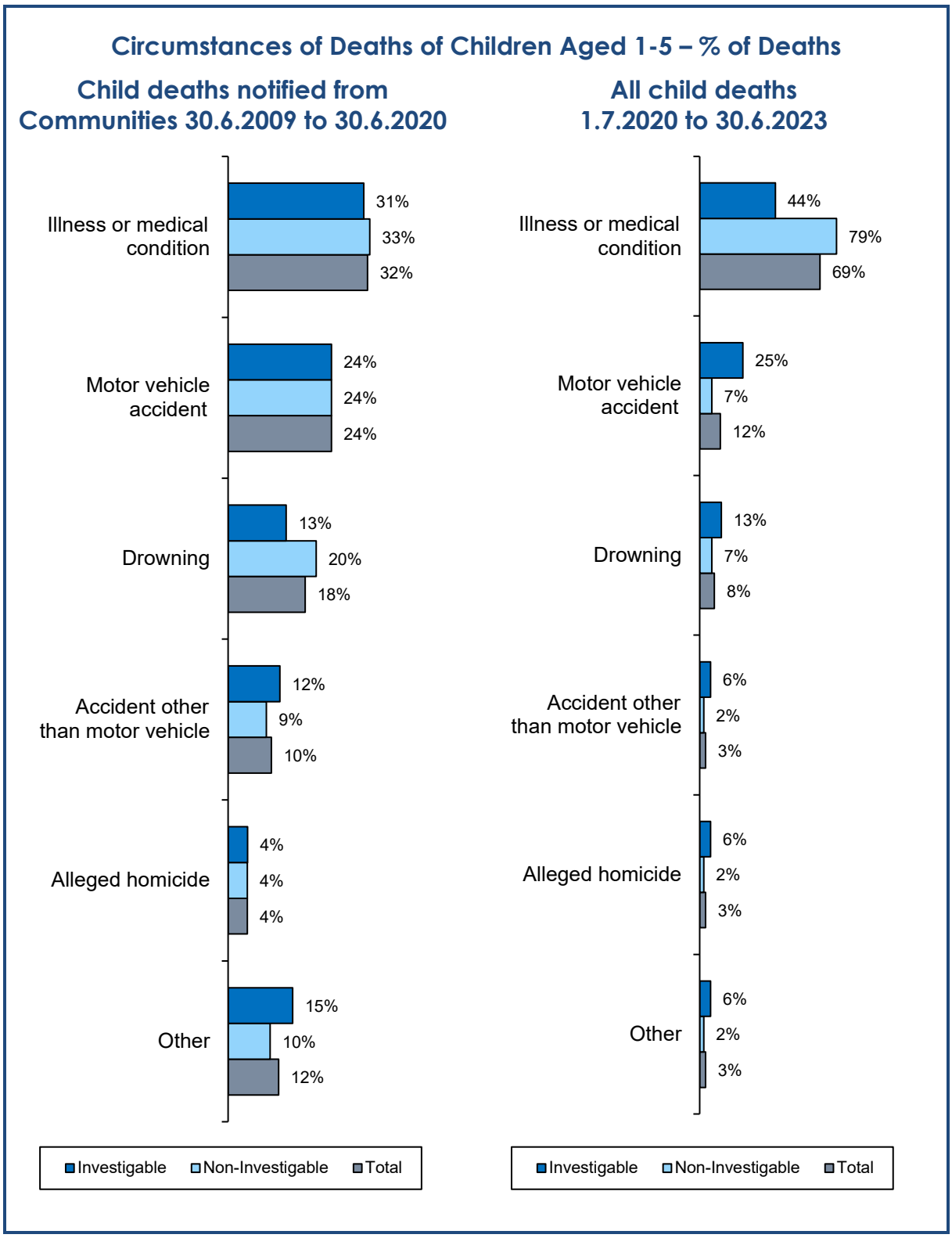
As shown in the following chart, illness or medical condition is the most common circumstance of death for this age group (41%), followed by motor vehicle accidents (21%) and drowning (15%).

Circumstances of Deaths of Children Aged 1-5



Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



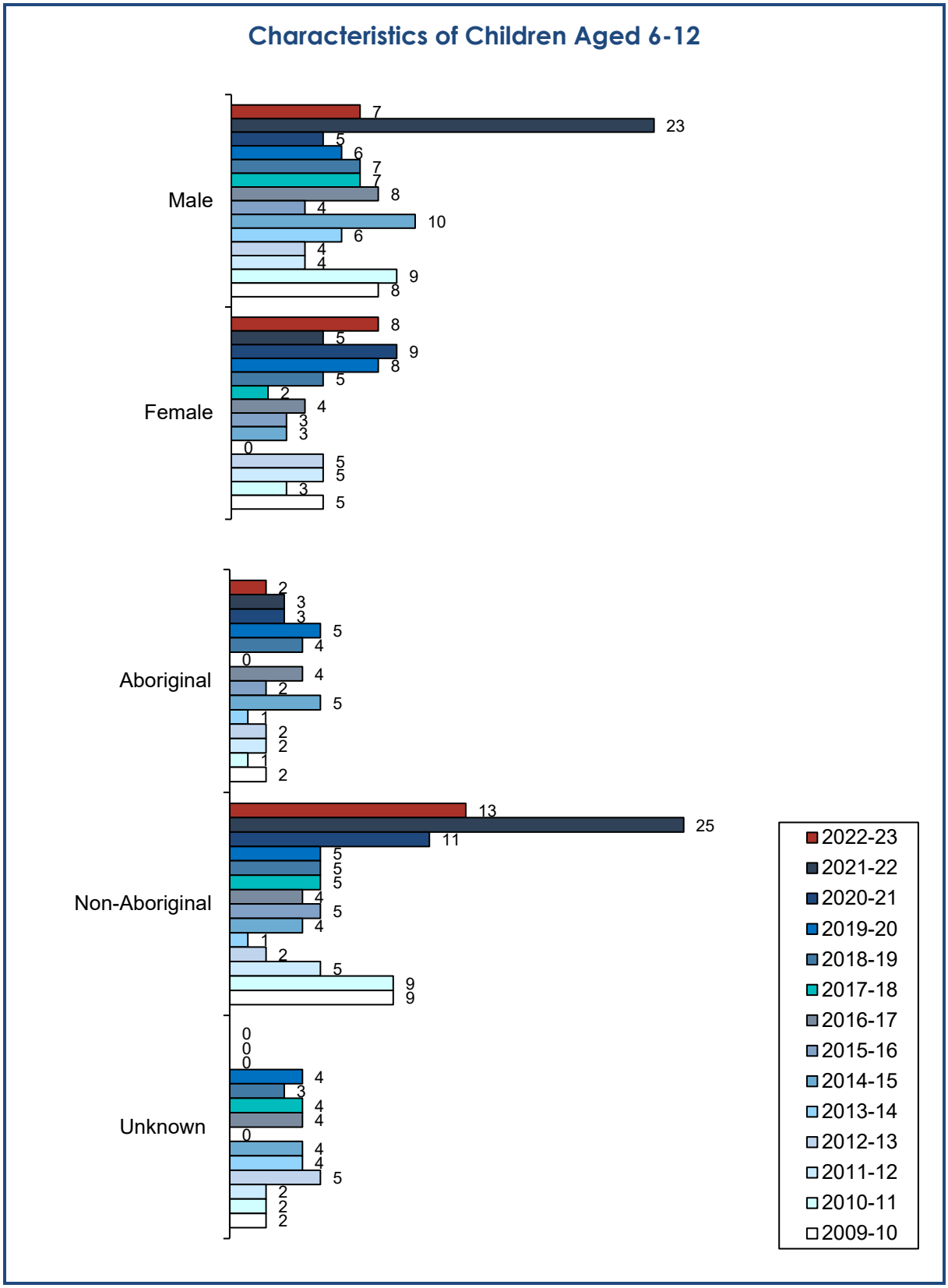
Note: Percentages may not add to 100 per cent due to rounding.

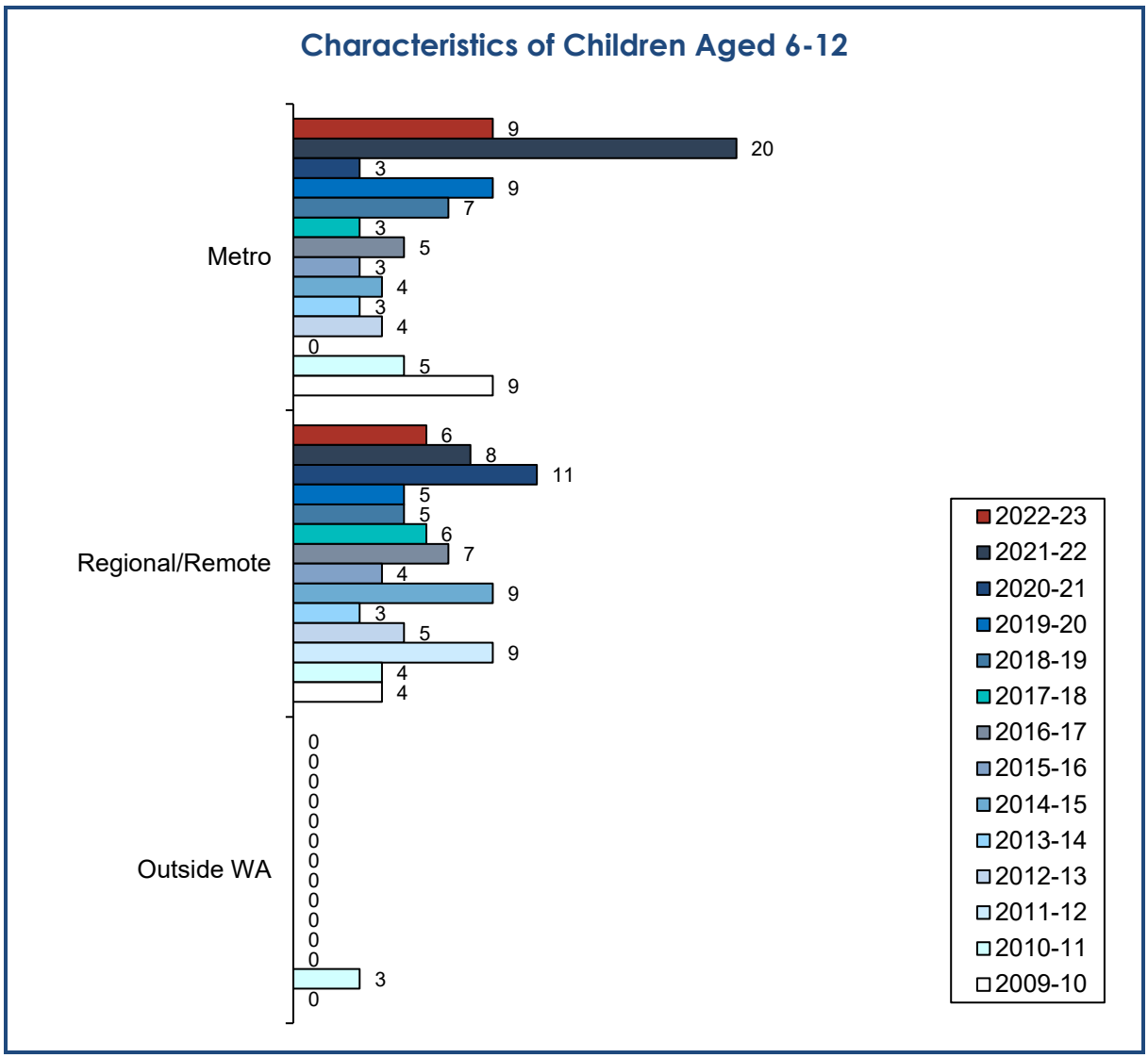
Eighty three deaths of children aged 1 to 5 years were determined to be investigable deaths.

Deaths of children aged 6 to 12 years

Of the 1,367 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 173 (13%) related to children aged from 6 to 12 years.

The characteristics of children aged 6 to 12 are shown in the following chart.





Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

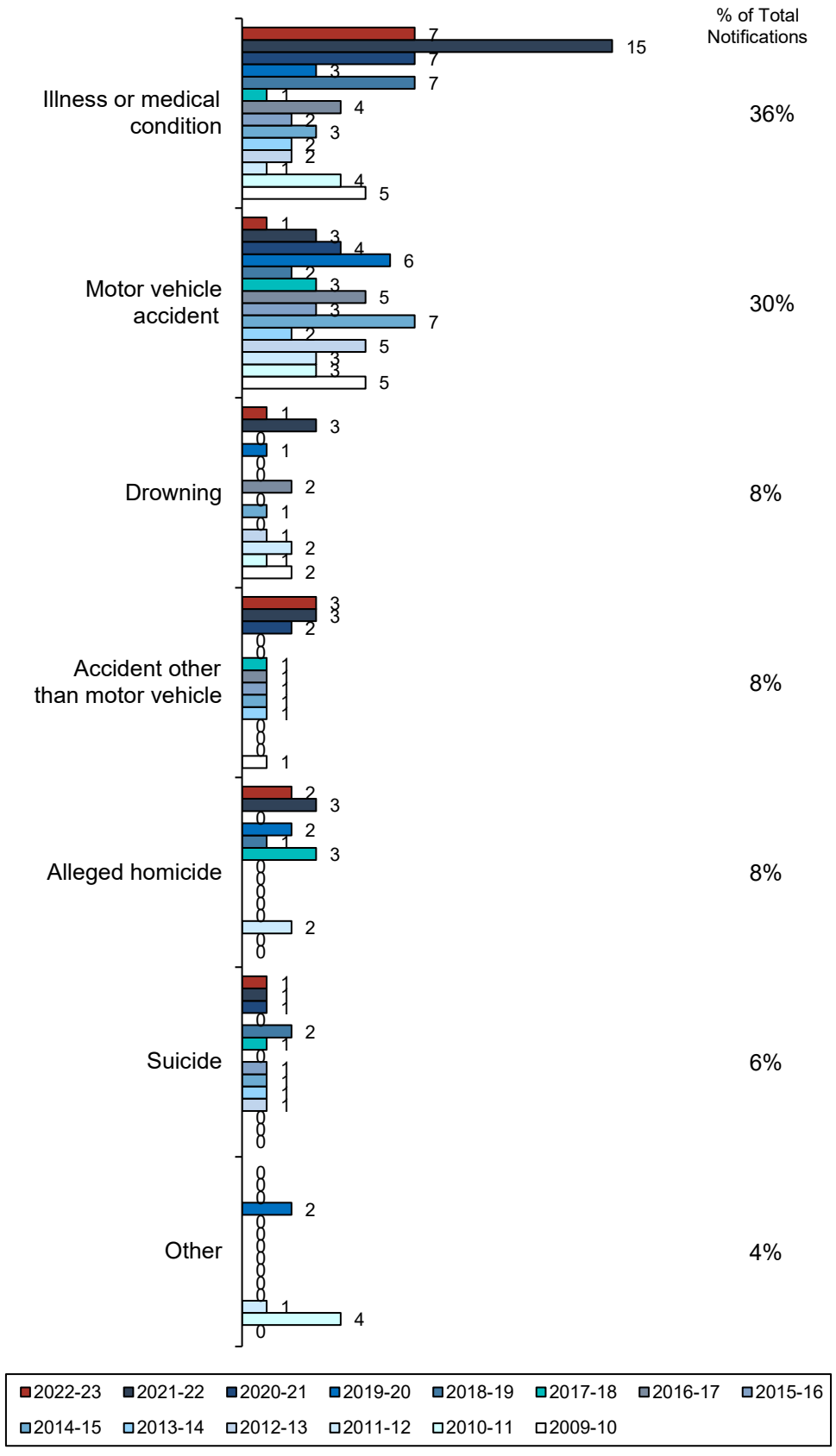
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 55% of investigable deaths and 67% of non-investigable deaths of children aged 6 to 12 were male compared to 51% in the child population;
- Aboriginal children – 47% of investigable deaths and 10% of non-investigable deaths of children aged 6 to 12 were Aboriginal children compared to 6% in the child population; and
- Children living in regional or remote locations – 58% of investigable deaths and 46% of non-investigable deaths of children aged 6 to 12, living in Western Australia, were children living in regional or remote locations compared to 26% in the child population.

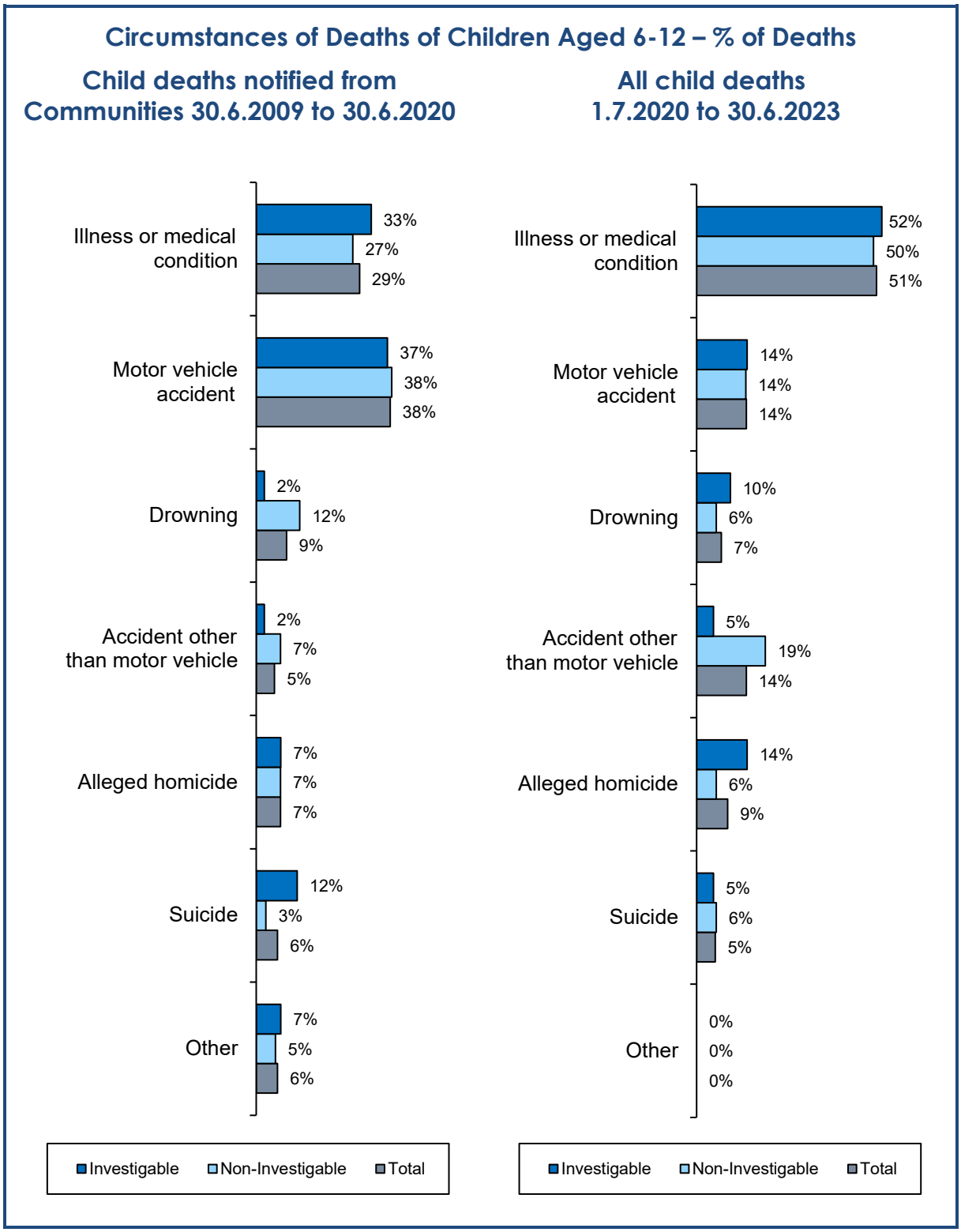
As shown in the following chart, illness or medical conditions are the most common circumstance of death for this age group (36%), followed by motor vehicle accidents (30%).

Circumstances of Deaths of Children Aged 6-12



Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



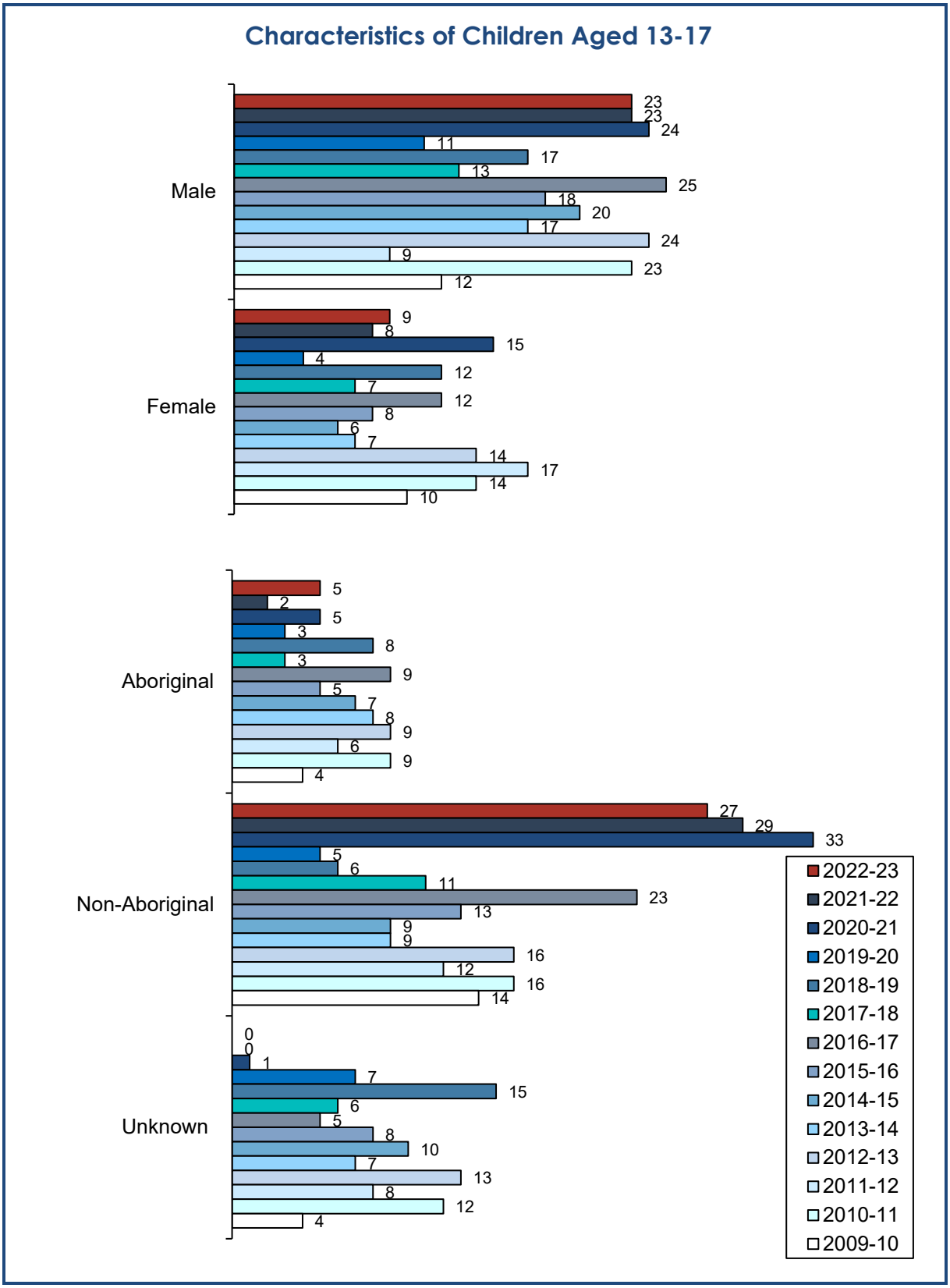
Note: Percentages may not add to 100 per cent due to rounding.

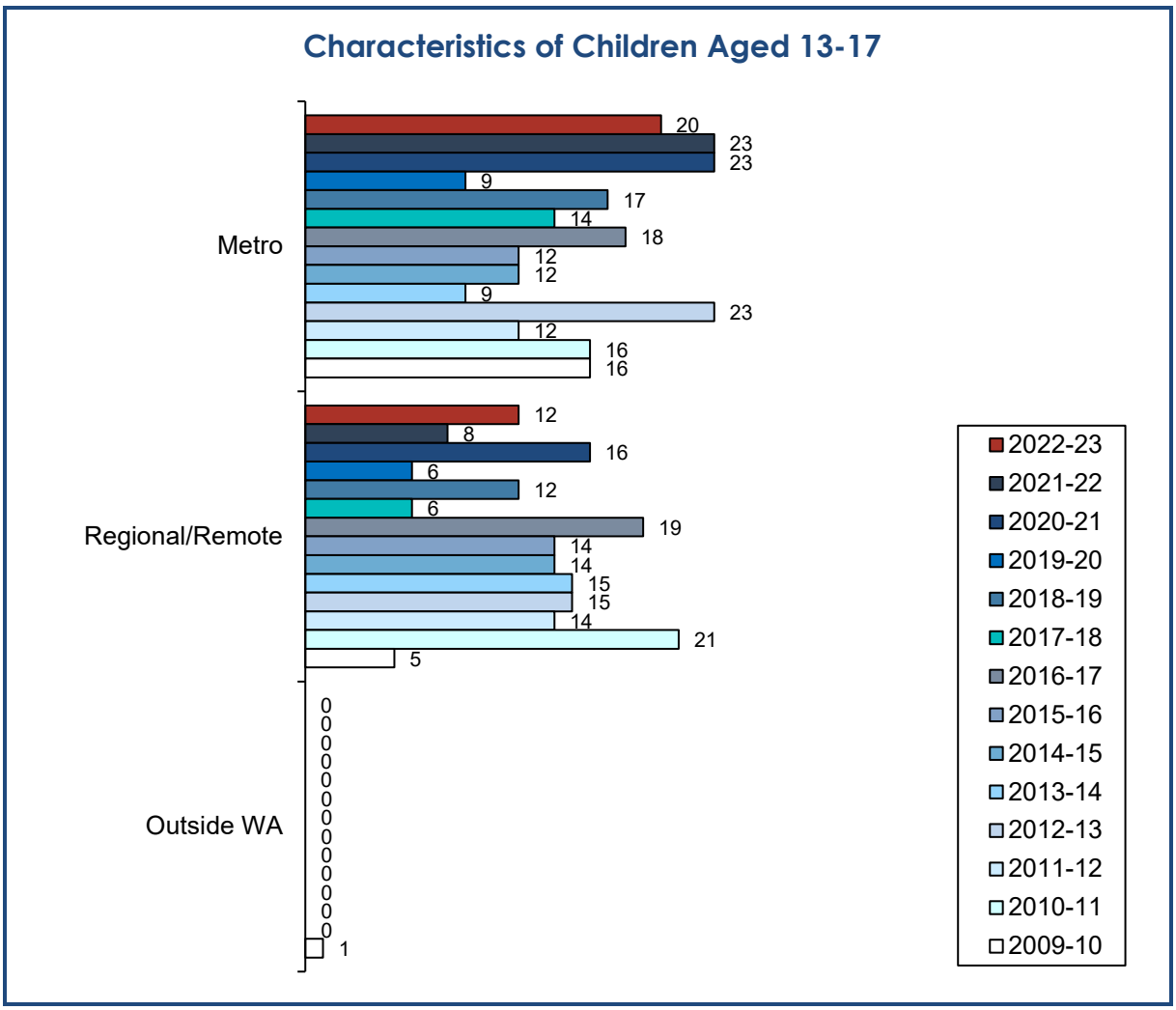
Sixty four deaths of children aged 6 to 12 years were determined to be investigable deaths.

Deaths of children aged 13 – 17 years

Of the 1,367 child death notifications received by the Ombudsman from 30 June 2009 to 30 June 2023, there were 402 (29%) related to children aged from 13 to 17 years.

The characteristics of children aged 13 to 17 are shown in the following chart.





Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

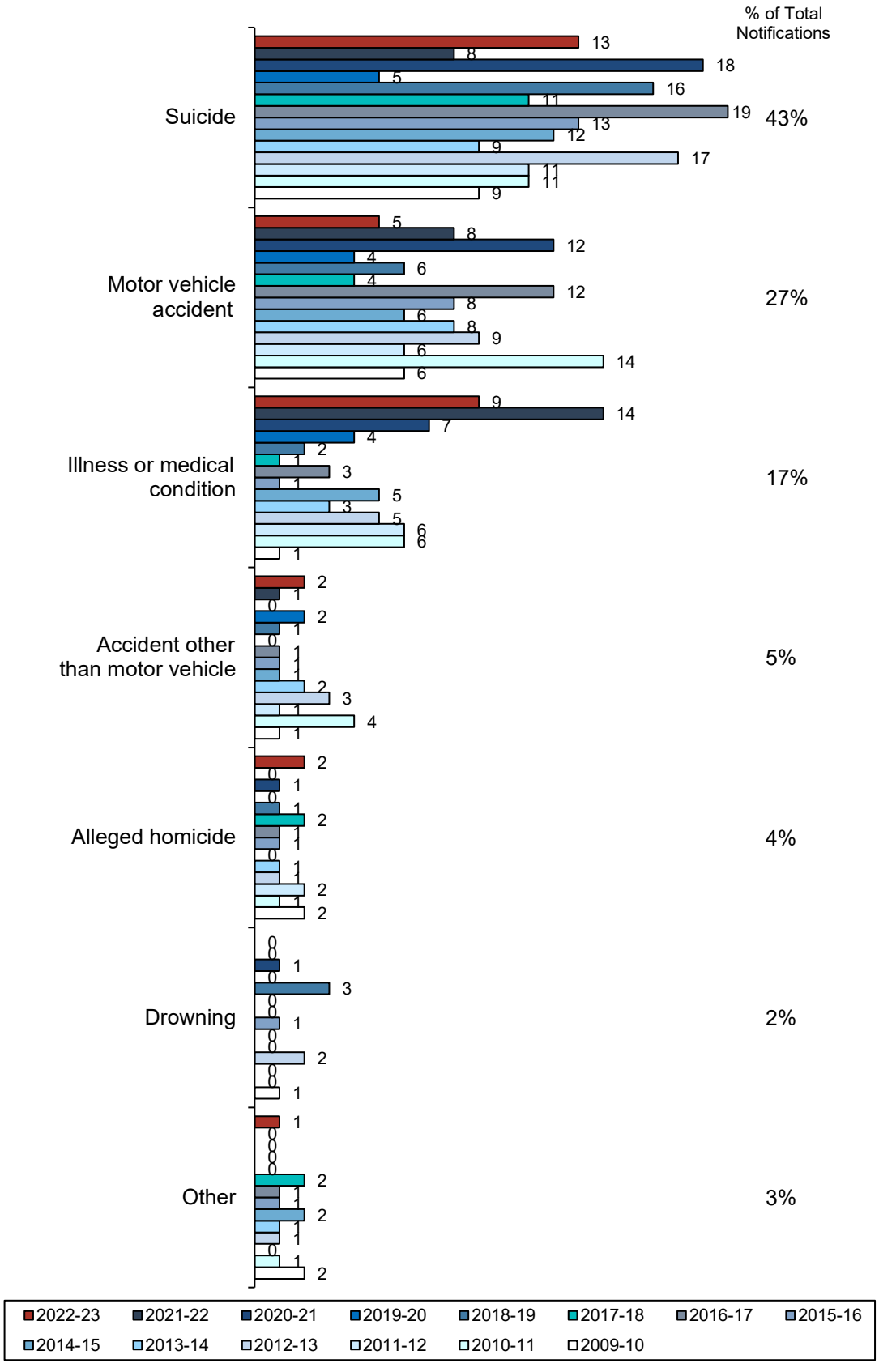
Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 60% of investigable deaths and 68% of non-investigable deaths of children aged 13 to 17 were male compared to 51% in the child population;
- Aboriginal children – 45% of investigable deaths and 9% of non-investigable deaths of children aged 13 to 17 were Aboriginal compared to 6% in the child population; and
- Children living in regional or remote locations – 53% of investigable deaths and 38% of non-investigable deaths of children aged 13 to 17, living in Western Australia, were living in regional or remote locations compared to 26% in the child population.

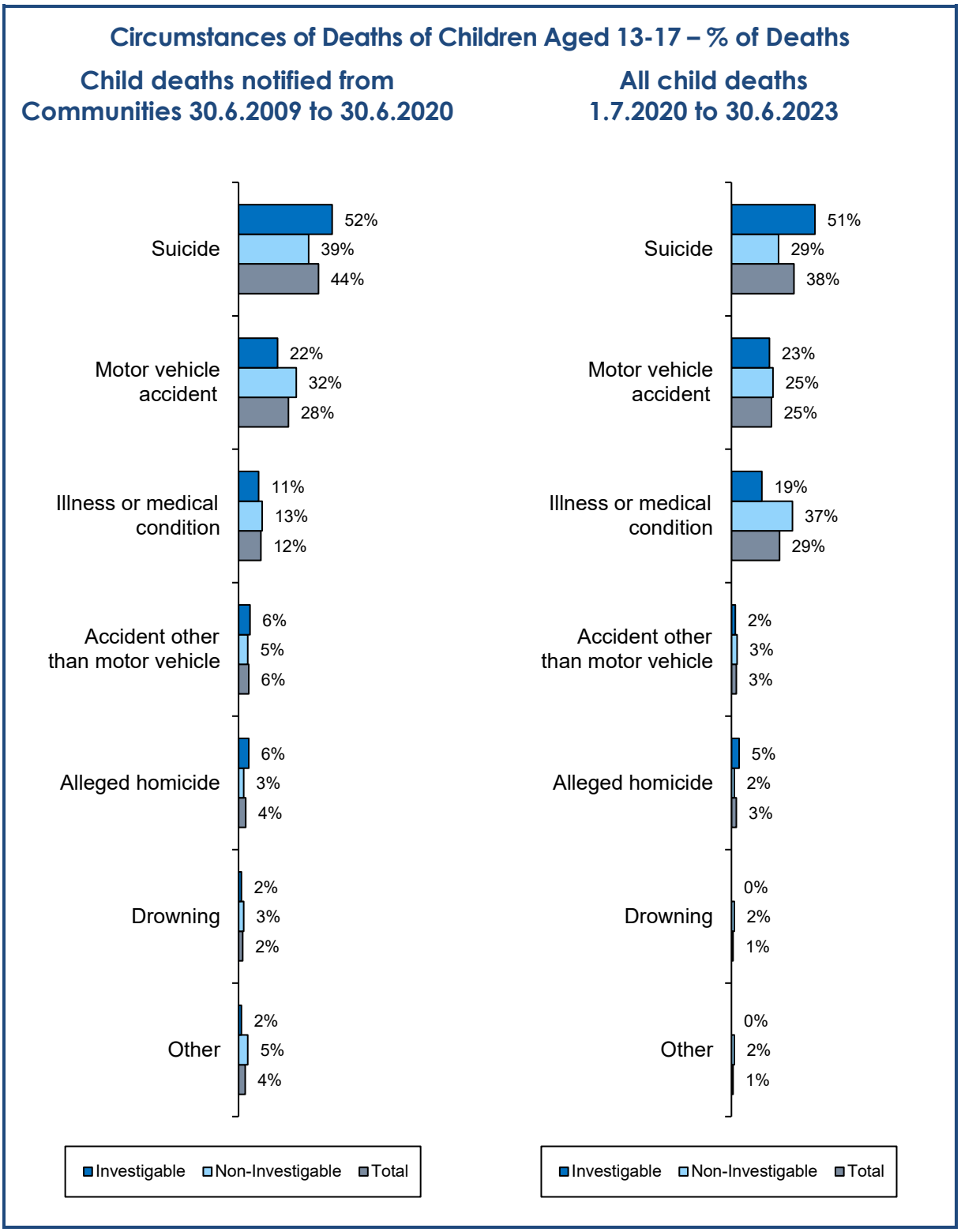
As shown in the following chart, suicide is the most common circumstance of death for this age group (43%), particularly for investigable deaths, followed by motor vehicle accidents (27%) and illness or medical condition (17%).

Circumstances of Deaths of Children Aged 13-17



Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.



Note: Percentages may not add to 100 per cent due to rounding.

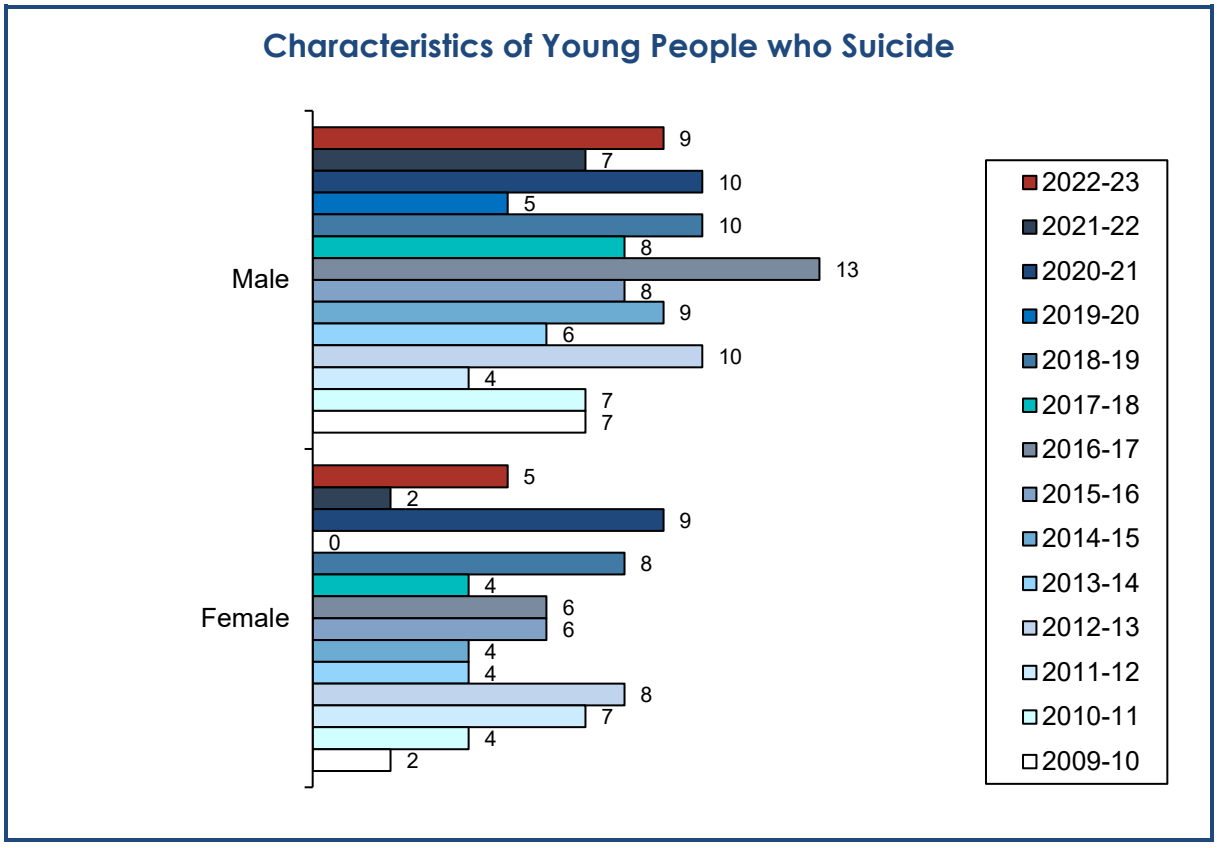
One hundred and sixty eight deaths of children aged 13 to 17 years were determined to be investigable deaths.

Suicide by young people

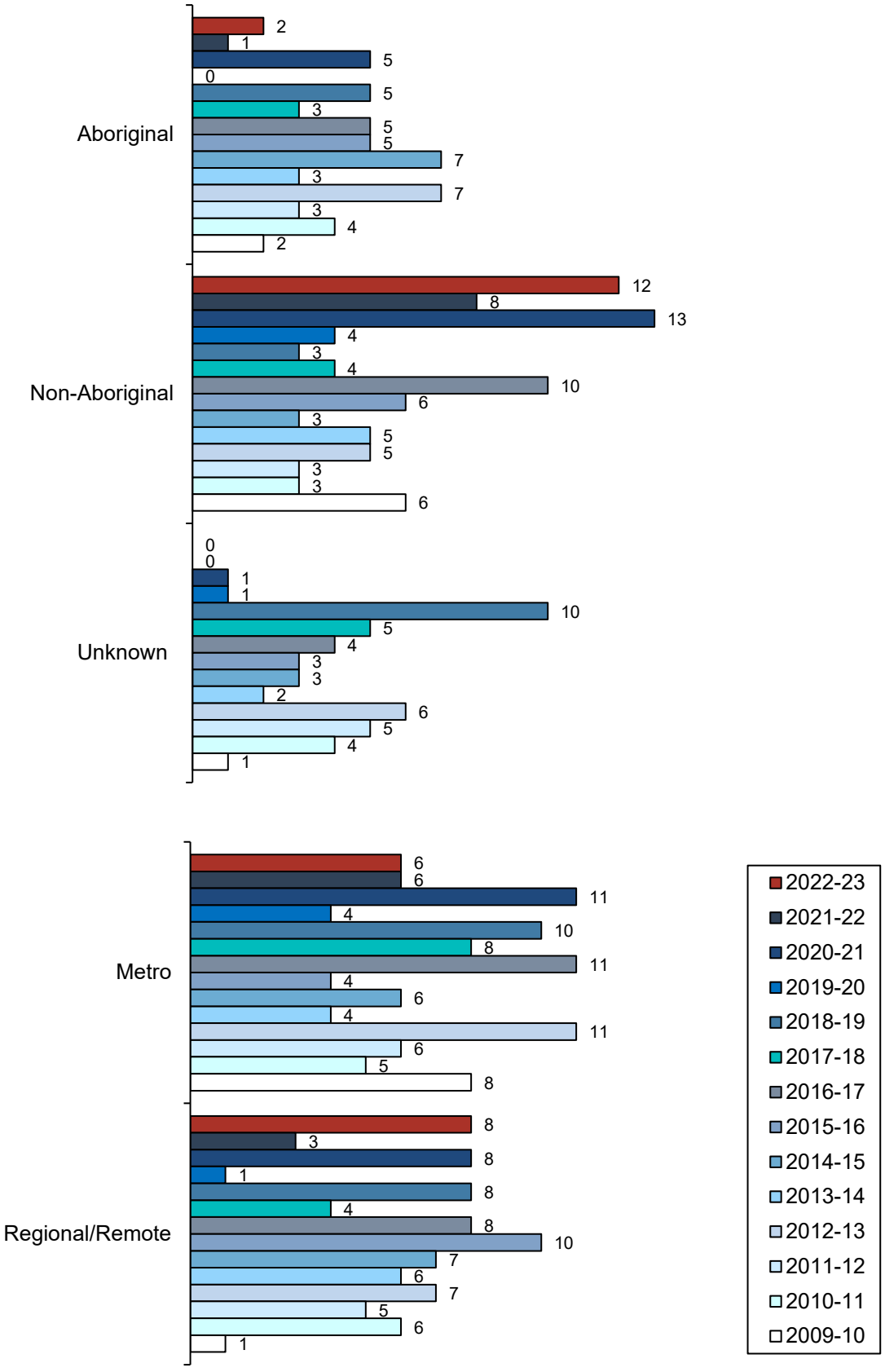
Of the 182 young people who apparently took their own lives from 30 June 2009 to 30 June 2023:

- Ten were under 13 years old;
- Twelve were 13 years old;
- Twenty were 14 years old;
- Thirty nine were 15 years old;
- Forty seven were 16 years old; and
- Fifty four were 17 years old.

The characteristics of the young people who apparently took their own lives are shown in the following chart.



Characteristics of Young People who Suicide



Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner.

Further analysis of the data shows that, for these deaths, there was an over-representation compared to the child population for:

- Males – 54% of investigable deaths and 71% of non-investigable deaths were male compared to 51% in the child population;
- Aboriginal young people – for the 137 apparent suicides by young people where information on the Aboriginal status of the young person was available, 55% of the investigable deaths and 11% of non-investigable deaths were Aboriginal young people compared to 6% in the child population; and
- Young people living in regional and remote locations – the majority of apparent suicides by young people occurred in the metropolitan area, but 57% of investigable suicides by young people and 33% of non-investigable suicides by young people were young people who were living in regional or remote locations compared to 26% in the child population.

Deaths of Aboriginal children

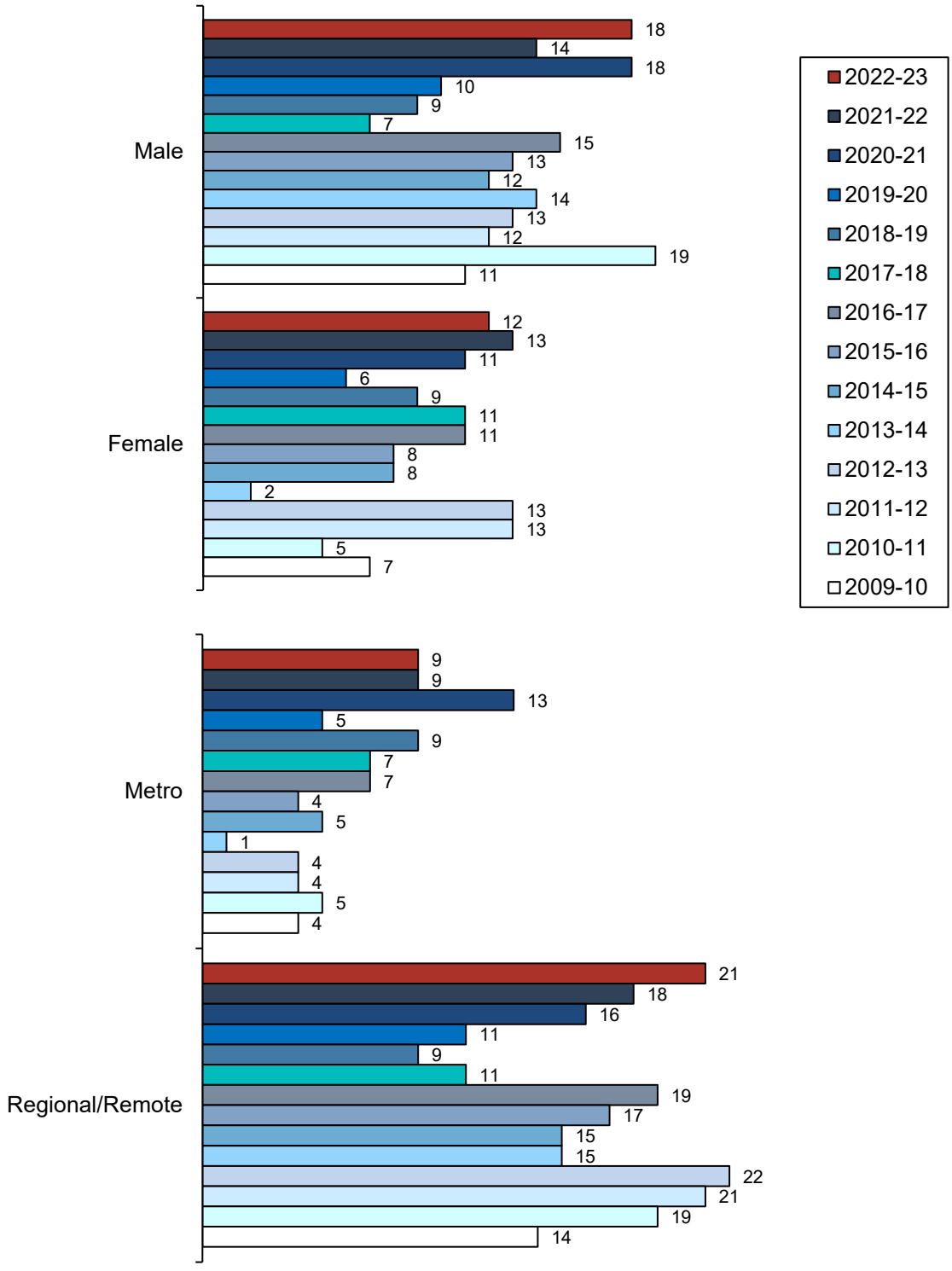
Of the 1,038 child death notifications received from 30 June 2009 to 30 June 2023, where the Aboriginal status of the child, or their parent/s, was recorded by agencies they had contact with in documentation provided to this Office, 314 (30%) of the children were identified as Aboriginal.[1]

For the notifications received:

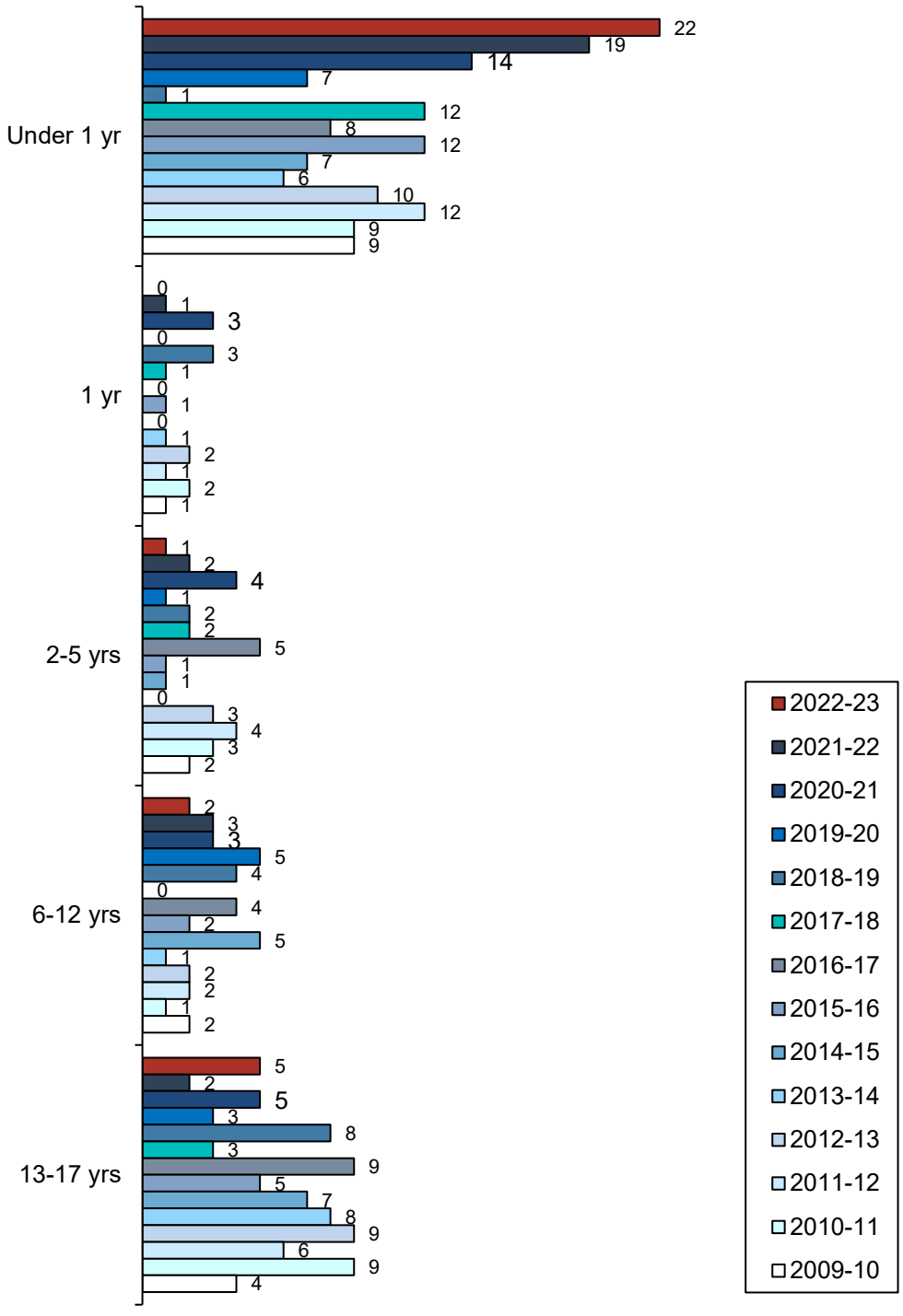
- Over the 14 year period from 30 June 2009 to 30 June 2023, the majority of Aboriginal children who died were male (59%). For 2022-23, 60% of Aboriginal children who died were male;
- Most of the Aboriginal children who died were under the age of one or aged 13-17; and
- The deaths of Aboriginal children living in regional communities far outnumber the deaths of Aboriginal children living in the metropolitan area. Over the 14 year period, 73% of Aboriginal children who died lived in regional or remote communities.

[1] "Aboriginal" includes children who are Torres Strait Islander and children who are both Aboriginal and Torres Strait Islander. Use of the term "Aboriginal" reflects the fact that the principal heritage of the first Western Australians are Aboriginal Western Australians and is in no way intended to exclude Torres Strait Islander people.

Characteristics of Aboriginal Children who Died



Characteristics of Aboriginal Children who Died

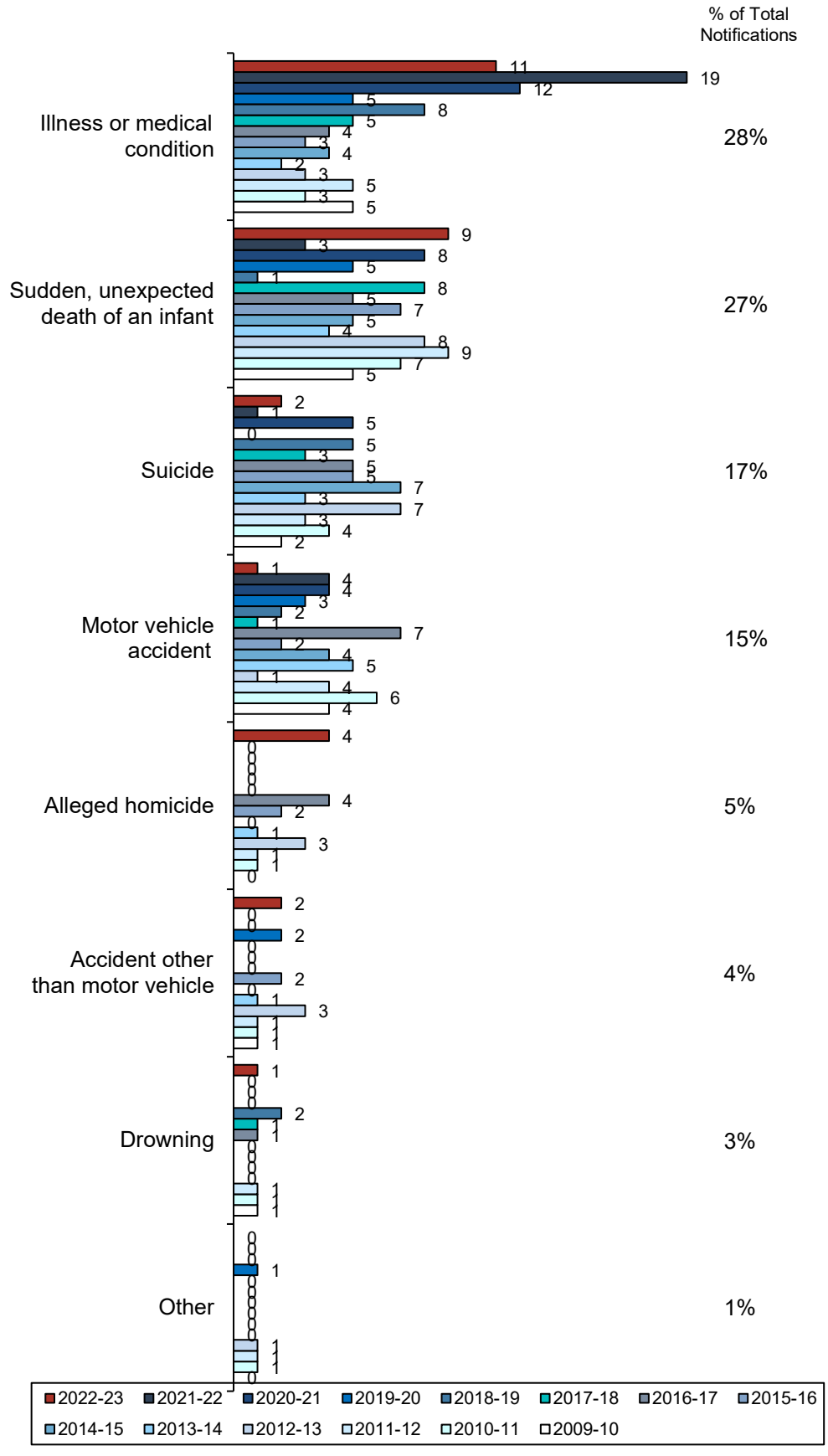


Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner..

As shown in the following chart, illness or medical condition (28%), sudden, unexpected deaths of infants (27%), suicide (17%), and motor vehicle accidents (15%) are the largest circumstance of death categories for the 314 Aboriginal child death notifications received in the 14 years from 30 June 2009 to 30 June 2023. However, 42 (47%) of reported deaths in circumstances of illness or medical condition are in the three years since 1 July 2020 when the jurisdiction expanded to all child deaths.

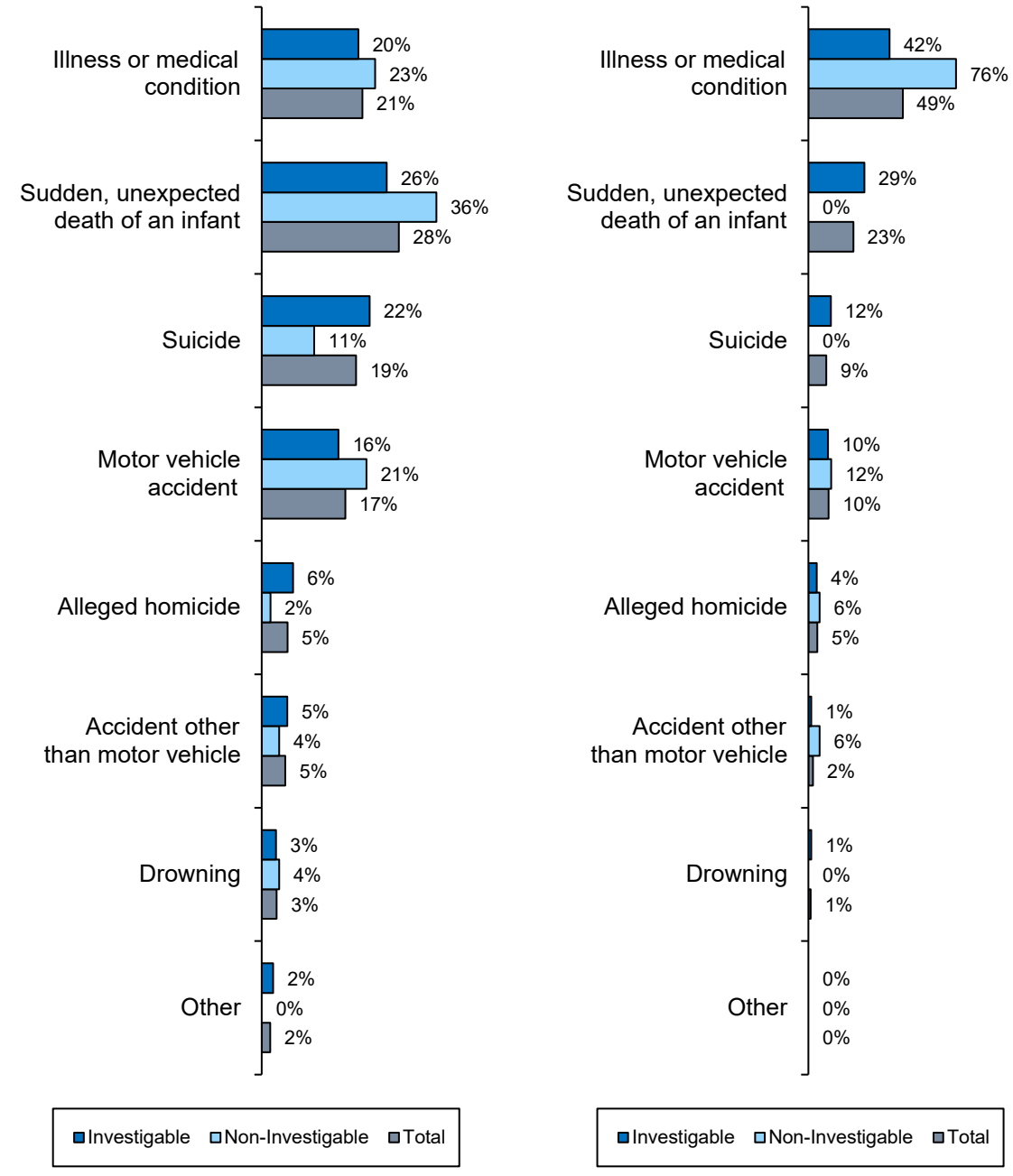
Circumstances of Deaths of Aboriginal Children



Note 1: Numbers may vary slightly from those previously reported as, during the course of a review, further information may become available.

Note 2: From 2020-21, the Ombudsman received notifications of all child deaths in Western Australia. In prior years, the Ombudsman received notifications from Communities of deaths reported to the Coroner..

Circumstances of Aboriginal Child Deaths – % of Deaths



Note: Percentages may not add to 100 per cent due to rounding.

Patterns, Trends and Case Studies Relating to Child Death Reviews

Deaths of infants

Sleep-related infant deaths

Through the undertaking of child death reviews, the Office identified a need to undertake an own motion investigation into the number of deaths that had occurred after infants had been placed to sleep, referred to as 'sleep-related infant deaths'.

The investigation principally involved the Department of Health but also involved the (then) Department for Child Protection and the (then) Department for Communities. The objectives of the investigation were to analyse all sleep-related infant deaths notified to the Office, consider the results of our analysis in conjunction with the relevant research and practice literature, undertake consultation with key stakeholders and, from this analysis, research and consultation, recommend ways the departments could prevent or reduce sleep-related infant deaths.

The investigation found that the Department of Health had undertaken a range of work to contribute to safe sleeping practices in Western Australia, however, there was still important work to be done. This work particularly included establishing a comprehensive statement on safe sleeping that would form the basis for safe sleeping advice to parents, including advice on modifiable risk factors, that is sensitive and appropriate to both Aboriginal and culturally and linguistically diverse communities and is consistently applied state-wide by health care professionals and non-government organisations at the antenatal, hospital-care and post-hospital stages. This statement and concomitant policies and practices should also be adopted, as relevant, by the (then) Department for Child Protection and the (then) Department for Communities.

The investigation also found that a range of risk factors were prominent in sleep-related infant deaths reported to the Office. Most of these risk factors are potentially modifiable and therefore present opportunities for the departments to assist parents, grandparents and carers to modify these risk factors and reduce or prevent sleep-related infant deaths.

The report of the investigation, titled *Investigation into ways that State Government departments and authorities can prevent or reduce sleep-related infant deaths,* was tabled in Parliament in November 2012. The report made 23 recommendations about ways to prevent or reduce sleep-related infant deaths, all of which were accepted by the agencies involved.

The implementation of the recommendations is actively monitored by the Office.

Case Study

Baby A

Baby A died while co-sleeping with a parent. In the year prior to Baby A's death, Communities had received 10 notifications relevant to the safety and wellbeing of Baby A and Baby A's older sibling. In reviewing these notifications and associated documented actions, the Ombudsman's review identified that Central Intake Team actions were not fully compliant with practice requirements. As previous child death reviews undertaken by the Ombudsman had noted similar issues, further examination by this office of Central Intake Team governance and monitoring identified areas for improvement. The Ombudsman made the following recommendation:

> Communities provides the Ombudsman with a report within three months of the finalisation of this review that outlines Communities' current and/or proposed schedule and framework for Central Intake Team reporting to:
>
> 1. enable monitoring of notification management and outcomes;
> 2. provide analysis on notification characteristics for trend analysis; and
> 3. inform management and executive of operational performance and efficiency.

Deaths of children aged 1 to 5 years

Deaths from drowning

The *Royal Life Saving Society – Australia: National Drowning Report 2014* (available at www.royallifesaving.com.au) states that:

> Children under five continue to account for a large proportion of drowning deaths in swimming pools, particularly home swimming pools. It is important to ensure that home pools are fenced with a correctly installed compliant pool fence with a self-closing and self-latching gate…
> (page 8)

The report of the investigation, titled *Investigation into ways to prevent or reduce deaths of children by drowning*, was tabled in Parliament on 23 November 2017. The report made 25 recommendations about ways to prevent or reduce child deaths by drowning, all of which were accepted by the agencies involved.

The Ombudsman's *Investigation into ways to prevent or reduce deaths of children by drowning* noted that for 47 per cent of the child drownings examined, the fatal drowning incident occurred in a private swimming pool. Further, that for 66 per cent of the hospital admissions for drowning examined, the non-fatal drowning incident occurred in a swimming pool. It was also noted that for fatal drownings examined, children aged one to four years who died by drowning, the incident more frequently occurred in a private swimming pool. Of the 25 recommendations made by the Ombudsman in the *Investigation into ways to prevent or reduce deaths of children by drowning*, 22 related to the construction and inspection of residential pool fencing.

A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning, tabled in Parliament in November 2018, identified that steps have been taken to give effect to the Ombudsman's recommendations.

The *Royal Life Saving National Drowning Report 2021* noted that for 1 July 2020 to 30 June 2021, nationally '[drowning] deaths among children aged 0-4 years increased by 9% compared with the 10-year average and 108% compared with last year'.

Deaths of children aged 6 to 12 years

The Ombudsman's examination of reviews of deaths of children aged six to 12 years has identified the critical nature of certain core health and education needs. Where these children are in the CEO's care, inter-agency cooperation between Communities, the Department of Health and the Department of Education (**DOE**) in care planning is necessary to ensure the child's health and education needs are met. Where multiple agencies may be involved in the life of a child and their family, it is important that agencies work collaboratively, and from a culturally informed position where relevant, to promote the child's safety and wellbeing.

Care planning for children in the CEO's care

Through the undertaking of child death reviews, the Office identified a need to undertake an investigation of planning for children in the care of the CEO of the (then) Department for Child Protection – a particularly vulnerable group of children in our community.

This investigation involved the (then) Department for Child Protection, the Department of Health and DOE and considered, among other things, the relevant provisions of the *Children and Community Services Act 2004*, the internal policies of each of these departments along with the recommendations arising from the Ford Report.

The investigation found that in the five years since the introduction of the *Children and Community Services Act 2004*, these three departments had worked cooperatively to operationalise the requirements of the Act. In short, significant and pleasing progress on improved planning for children in care had been achieved, however, there was still work to be done, particularly in relation to the timeliness of preparing care plans and ensuring that care plans fully incorporate health and education needs, other wellbeing issues, the wishes and views of children in care and that they are regularly reviewed.

The report of the investigation, titled *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004*, was tabled in Parliament in November 2011.

The report made 23 recommendations that were designed to assist with the work to be done, all of which were agreed to by the relevant departments.

The implementation of the recommendations is actively monitored by the Office.

Deaths of primary school aged children from motor vehicle accidents

In 2022-23, the Ombudsman received one notification of the death of a child aged six to 12 years in the circumstances of motor vehicle accident. This death occurred in regional or remote Western Australia. Considering all 14 years from 30 June 2009 to 30 June 2023, 67% of notifications of the deaths of children aged six to 12 in the circumstances of motor vehicle accidents occurred in regional or remote Western Australia.

Deaths of children aged 13 to 17 years

Suicide by young people

Of the child death notifications received by the Office since the commencement of the Office's child death review responsibility, nearly a quarter related to children aged 13 to 17 years old. Of these children, suicide was the most common circumstance of death, accounting for 43% of deaths. Furthermore, and of serious concern, Aboriginal children were very significantly over-represented in the number of young people who died by suicide. For these reasons, the Office decided to undertake a major own motion investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people.

The objectives of the investigation were to analyse, in detail, deaths of young people who died by suicide notified to the Office, comprehensively consider the results of this analysis in conjunction with the relevant research and practice literature, undertake consultation with government and non-government stakeholders and, if required, recommend ways that agencies can prevent or reduce suicide by young people.

The Office found that State Government departments and authorities had already undertaken a significant amount of work that aimed to prevent and reduce suicide by young people in Western Australia, however, there was still more work to be done. The Office found that this work included practical opportunities for individual agencies to enhance their provision of services to young people. Critically, as the reasons for suicide by young people are multi-factorial and cross a range of government agencies, the Office also found that this work included the development of a collaborative, inter-agency approach to preventing suicide by young people. In addition to the Office's findings and recommendations, the comprehensive level of data and analysis contained in the report of the investigation was intended to be a valuable new resource for State Government departments and authorities to inform their planning and work with young people. In particular, the Office's analysis suggested this planning and work target four groups of young people that the Office identified.

The report of the investigation, titled *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, was tabled in Parliament in April 2014 (**the 2014 Investigation**). The report made 22 recommendations about ways to prevent or reduce suicide by young people, all of which were accepted by the agencies involved.

Preventing suicide by children and young people 2020, tabled in Parliament in September 2020, identified that steps have been taken to give effect to the Ombudsman's recommendations from the 2014 Investigation and examined a further 79 deaths by suicide that occurred following the 2014 Investigation. Further details are provided in the Own Motion Investigations, Monitoring and Improvement section of this Annual Report.

Issues Identified in Child Death Reviews

The following are the types of issues identified when undertaking child death reviews.

It is important to note that:

- Issues are not identified in every child death review; and
- When an issue has been identified, it does not necessarily mean that the issue is related to the death of a child.

- Not undertaking sufficient intra-agency and inter-agency communication to enable effective case management and collaborative responses to promote child safety and wellbeing.
- Not appropriate culturally responsive practice.
- Not adequately assessing the need for an interpreter.
- Missed opportunity to appropriately consider child care arrangements when arresting a parent.
- Not taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004*, and associated policy, to determine whether children were in need of protection or whether action was required to safeguard child wellbeing.
- Not taking action consistent with legislative responsibilities of the *Children and Community Services Act 2004* for a child in the CEO's care.
- Not providing approvals to decisions in accordance with the instrument of delegations.
- Not adequately meeting Central Intake Team practices to appropriately respond to child wellbeing reports.
- Not adequately meeting policies and procedures relating to Child Safety Investigations and safety planning.
- Not adequately meeting policies and procedures relating to *Intensive Family Support*.
- Not adequately meeting policies and procedures relating to high-risk infants, including placement on the Monitored List in contravention of practice requirements.
- Not adequately meeting policies and procedures relating to pre-birth planning.
- Not adequately meeting policies and procedures relating to family and domestic violence.
- Not adequately meeting policies and procedures relating to the assessment of parental drug and alcohol use, and mental health issues.
- Not sufficient governance, monitoring and evaluation of the efficiency and effectiveness of agency operations including the Central Intake Team and management of the Monitored List.
- Not meeting recordkeeping requirements.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce child deaths. The following four recommendations were made by the Ombudsman in 2022-23 arising from child death reviews (certain recommendations may be de-identified to ensure confidentiality).

1. That Communities considers the findings of this review, (and as appropriate the outcomes of any other relevant reviews of the deaths of children by the Ombudsman), and provides the Ombudsman, within three months of the finalisation of this review, with:

    a) a safety plan considered appropriate in the circumstances of a high-risk infant's post-birth hospital discharge, that exemplifies Communities use of its legislative powers under the *Children and Community Services Act 2004*, to promote child wellbeing and safety; and

    b) a response on whether there are any systemic issues across Communities in developing adequate safety plans, and if improvement is required, outlines Communities plans to strengthen systems, processes and best practice associated with the administration of safety plans to support improved outcomes for vulnerable children and families in the circumstances of alleged parental substance use, mental health issues and perpetration of family and domestic violence. This response should include the role of the Chief Practitioner.

2. That Communities provides a report to the Ombudsman on the progress of the implementation of the 'system enhancements being developed to prevent High-Risk Infants (HRIs) from being placed on the Monitored List' by 31 March 2023.

3. Communities provides the Ombudsman with a report within three months of the finalisation of this review that outlines Communities' current and/or proposed schedule and framework for Central Intake Team reporting to:

    1. enable monitoring of notification management and outcomes;
    2. provide analysis on notification characteristics for trend analysis; and
    3. inform management and executive of operational performance and efficiency.

4. That Communities undertakes an internal review to ascertain how the issues identified in this child death review occurred and provides a report to the Ombudsman, within six months of the finalisation of this review, outlining the review findings and whether action is required to facilitate:

    - Timely service of s.143 proposals in accordance with the requirements of the *Children and Community Services Act 2004*;
    - Incorporation of all Children's Court outcomes relevant to the Department's decision making for a child's safety and wellbeing; and
    - Adherence to the CEO's Instrument of Delegation for approvals relevant to decisions and actions for a child in CEO care.

The Ombudsman's *Annual Report 2023-24* will report on the steps taken to give effect to the eight recommendations made about ways to prevent or reduce child deaths in 2021-22. The Ombudsman's *Annual Report 2024-25* will report on the steps taken to give effect to the four recommendations made about ways to prevent or reduce child deaths in 2022-23.

Steps taken to give effect to the recommendations arising from child death reviews in 2020-21

The Ombudsman made eight recommendations about ways to prevent or reduce child deaths in 2020-21. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations; or
- If no such steps have been, or are proposed to be taken, the reasons therefor.

Recommendation 1: That Communities provides a report to the Ombudsman, within four months of the finalisation of this review, detailing Communities' strategies and/or practice guidelines for recognising and responding to reports of alcohol, drug and volatile substance use by children and young people.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 15 February 2021, in which Communities relevantly informed this Office that:

> Summarised in Table 1 below is information regarding Communities child protection practice guidance concerning young people who are using alcohol, drugs, or volatile substances, including identifying areas where guidance can be strengthened.
>
> The key points are:
>
> - practice guidance does not currently include information about when a wellbeing concern, such as a child using alcohol, drugs, or volatile substances, may be an indicator of abuse and neglect.
> - the interaction tool, which is used to inform decisions about intake for Child Safety Investigations, does not currently include a child's at-risk behaviours as a domain.
> - practice guidance focuses on responding to a child using alcohol, drugs, or volatile substances through family support. It currently doesn't direct when a child protection response is required, including in circumstances of wellbeing concerns co-presenting with emotional abuse - family and domestic violence, neglect, cumulative abuse and/or parent unable to provide adequate care; and
> - for children in care, the practice guidance is clearer, requiring child protection workers to refer to appropriate services, collaborate with the provider to ensure a collaborative approach, update the quarterly care review, and consult with their Team Leader.

> In addition, some districts have localised processes for responding to children using drugs, alcohol and volatile substances including 'Youth At Risk Meetings' and Volatile Substance Use meetings…

Table 1, as included in Communities' letter dated 15 February 2021, provides a summary of practice guidance at that time, indicating where improvements were required.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> On 15 February 2021, Communities provided a Progress Update to the Ombudsman…outlining the practice guidance available at the time, to assist child protection workers in recognising and responding to reports of alcohol, drug and volatile substance use by children and young people. The Progress Update identified that Communities' practice guidance in relation to at-risk youth could be strengthened and outlines Communities' Specialist Child Protection Unit was undertaking a cohort review of a sub-set of child deaths and family and domestic violence fatalities, which would inform an update of practice guidance.
>
> Current Status
>
> *Strengthening practice guidance*
>
> - Since the [Communities letter dated 15 February 2021] was provided to the Ombudsman, the Community Services Division progressed work to develop new CPM practice guidance in relation to at-risk youth.
> - This work was informed by findings from oversight agency child death reviews and FDV fatality reviews, and by internal analysis of themes and trends in child deaths and FDV fatalities.
> - In August 2021, the CPM entry 1.4.1 *Alcohol and other drug use – at risk young people* was uploaded. This entry includes guidance in relation to Volatile Substance Use.
>
> *At Risk Youth Strategy 2022-2027 (the Strategy)*
>
> - In March 2021 the Central Review Team met with the Community Services Division and provided input on findings from oversight agency reviews and internal analysis of themes and trends in child deaths and FDV fatalities, to be used to inform the Strategy. On 19 September 2022 Communities advised the Ombudsman of the availability of the Strategy online…

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 2: Communities provides the Ombudsman with a copy of the Australian Centre for Child Protection 'independent evaluation of the Interaction Tool' and/or a report outlining the findings and outcomes of the independent evaluation of the Centralised Intake Model, Interaction Tool and its state-wide implementation, when available.

Steps taken to give effect to the recommendation

Communities has now provided this Office with a copy of the Australian Centre for Child Protection, *Final Report: Review of the Central Intake Interaction Tool (November 2020)* and the Quantum Consulting Australia, *Review of the Central Intake Interaction Tool: Final Report (November 2021).* These reports included recommendations to improve effectiveness of the Interaction Tool.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> On 30 June 2022, Communities provided the *Review of the Central Intake Interaction Tool* (the Review), to the Ombudsman.
>
> Current status
>
> The Review contains 18 recommendations for Communities' consideration. Communities Statewide Referral and Response Service developed three documents which detail Communities' response to, and planning for implementation of, the Review recommendations:
>
> - the *Interaction Tool Project on a Page*;
> - *Interaction Tool program logic*; and
> - *Quantum Consulting Australia Recommendations Response*.
>
> On 19 September 2022, Communities provided the Ombudsman with the above noted three documents.
>
> The Interaction Tool Project, involving the embedding of the Interaction Tool into Assist (commencing 1 March 2023) supports the implementation of recommendations one, two, three, 14 and 15 from the Review. Recommendations 16, 17 and 18 relate to plans to evaluate the Interaction Tool after its embedment into Assist. The implementation of these recommendations will include data analysis at a later date.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 3: WA Country Health Service (WACHS) considers the findings of this child death review of Infant A, along with the findings of the child death reviews of Infant B and Infant C and actions taken by WACHS to implement the Ombudsman's associated June 2018 recommendations, to determine whether further action is required to:

- **Ensure that where risk indicators for an unborn child/infant are identified, appropriate assessments are undertaken and documented in accordance**

with the Department of Health Guidelines for Protecting Children 2015 (revised May 2017, or any subsequent revisions);

- **Ensure that where inquiries or referrals are made with Communities, all relevant risk information is shared;**
- **Improve understanding of the provisions under the *Child and Community Services Act 2004* (CCS Act) to protect health service providers from liability when they disclose confidential information related to the wellbeing of an unborn child/infant; and**
- **Improve knowledge of Communities' referral assessment processes (including what information is considered under the 22 prompts of the Interaction tool and the Casework Practice Manual section 2.2.18 High-risk infants) and the threshold for Communities in determining that action is required under the CCS Act, to promote effective communication and collaboration by WACHS in ensuring an unborn child/infant is safe from harm.**

Steps taken to give effect to the recommendation

WACHS provided this Office with a letter dated 15 October 2020, in which WACHS relevantly informed this Office that:

> Following this incident, with consideration given to the findings of this review, and lessons learnt from previous incidents that have occurred…I can confirm WACHS Region has implemented changes in order to prevent similar occurrences in the future. Please note that the following processes and regular meetings are now in place in the Region:
>
> 1. Hospital midwifery and maternity nursing staff now complete a mandatory FDV learning module.
> 2. The Clinical Midwives in the hospital Antenatal clinic complete FDV screening during the booking (initial) appointment. If risks are found, then a Child at Risk (CAR) alert is generated and entered onto the electronic patient record. All patients with CAR alerts are reviewed at the weekly High Risk Antenatal Meeting.
> 3. Introduction of a weekly High Risk Antenatal meeting…
> 4. A monthly hospital interdisciplinary Risk Assessment Group oversees the management of Child at Risk assessments…
> 5. A monthly Interagency Children at Risk Meeting…
>
> In addition, under the direction of the WACHS Clinical Director, Paediatrics the WACHS Child Protection Reference Group has been established to provide clinical advice and leadership regarding WACHS wide approach to Child Protection and includes clinical representatives from all the regions, the State Protection of Children Coordination Unit, Perth Children's Hospital Child Protection Unit and Department of Communities. This group will coordinate WACHS wide implementation of strategies arising from recommendations made by the Ombudsman in Child Death and Family and Domestic Violence Death cases.

This Office requested that WACHS inform the Office of any further information on the steps taken to give effect to the recommendation. In response, WACHS provided a range of information in a letter to this Office dated 8 May 2023, containing a report prepared by WACHS.

In WACHS's report, WACHS relevantly informed this Office that:

WACHS has collectively reviewed the three child death reviews.

Following are initiatives which have been implemented (or have commenced) since October 2022 when WACHS provided a letter outlining steps taken to address the recommendations associated with review of the death of Infant A.

Ensure that where risk indicators for an unborn child/infant are identified, appropriate assessments are undertaken and documented in accordance with the Department of Health Guidelines for Protecting Children 2020 (most recent revision)

- The *Guidelines for Protecting Children 2020* includes comprehensive information to support staff with recognising, responding, recording, and reporting child and abuse and neglect. This document underpins development of WACHS policies and practices.
- WACHS maternity services conduct risk assessments for all mothers and children (including unborn children) across a range of clinical and social criteria. Those identified to be at risk are provided with additional support from a social worker.
- WACHS updated its WebPAS Child at Risk Alert procedure to highlight requirements to establish Alerts for unborn children at risk.
- WACHS has established new a policy: Social Work Guidelines for high-risk families during pregnancy and the first year of life. This document guides the operational processes for WACHS social workers when they are involved with identifying, supporting, and managing vulnerable and high-risk families. The *Guidelines for Protecting Children 2020* is a key reference.
- Infants (including unborn infants) identified by WACHS maternity services as being at risk are referred to hospital-based interdisciplinary 'Baby at risk' meetings to plan follow-up required for the child and family. A standard term of reference is being developed for use by all relevant WACHS hospitals.
- The WACHS procedure for Special Referral to Child Health Services (from maternity services) is under review. Additional risk factors have been added to strengthen sharing information about social circumstances and home environments.
- The Stork Perinatal Database and the hard-copy form (used by private maternity providers) is being updated to reflect the strengthened risk criteria for Special Referrals to Child Health Services. This work has been collaborative across health service providers in WA Health.
- Emergency Department (ED) teams across WACHS have established paediatric injury forms to assist with the assessment of suspicious injury in children. The form is based on that used by Perth Children's Hospital.
- ED teams are able to access information from other WACHS services, such as:
    - the WebPAS Child at Risk Alert, which is well used across WACHS including maternity and mental health services.
    - the Community Health Information System (CHIS) for clinical information collected by child health nurses and/or child development (allied health) clinicians.
- ED teams implement safety-net meetings to plan follow-up actions required to protect children. This includes inquiries or referrals made to the Department of Communities.

- Work is currently underway to strengthen identification and responses by ED teams for cases of family and domestic violence, including situations involving children and/or unborn infants. Assessment proforma and related processes are being trialled and evaluated in WACHS hospitals.

Ensure that where inquiries or referrals are made with Communities, all relevant risk information is shared

- The WA Health *Guidelines for Protecting Children 2020* includes a chapter 'Reporting child abuse' with comprehensive information about formal notifications of a concern of child abuse. Figure 7. (p.56) guides WA health system staff on information to include in a report to the Department of Communities.
- The *Guidelines for Protecting Children 2020* has been distributed across WACHS and is used to inform development of all relevant WACHS policies, procedures, and protocols.
- WACHS has established new a policy: Social Work Guidelines for high-risk families during pregnancy and the first year of life. It includes communicating with and making referrals to the Department of Communities.
- Clinical Nurse Specialists (CNSs) are employed in community health teams in each of the WACHS regions. The work of CNSs supports families and children at risk and supports community health nurses working with vulnerable families. The CNSs are in frequent contact with Department of Communities staff and their work is closely aligned with WA Health *Guidelines for Protecting Children 2020*.

Improve understanding of the provisions under the Child and Community Services Act 2004 (CCS Act) to protect health service providers from liability when they disclose confidential information related to the wellbeing of an unborn child/infant

- The Statewide Protection of Children Coordination Unit (SPOCC Unit) has long provided resources and in-person or virtual training for WACHS staff. This includes supporting WACHS staff to understand the *Children and Community Services Act 2004* and the responsibilities of Health staff under the Act.
- Since 2022, the focus of SPOCC work shifted to provision of videos and other resources to support education relating to child abuse.
- In 2023 WACHS aims to work with SPOCC to develop a suite of online training for WACHS clinicians. This will enable WACHS to refine and monitor training for staff.
- A Child Safety toolbox SharePoint page has been developed for WACHS staff as a one-stop-shop for information and resources relating to child safety and protection.

Improve knowledge of Communities' referral assessment processes (including what information is considered under the 22 prompts of the Interaction tool and the Casework Practice Manual section 2.2.18 High-risk infants) and the threshold for Communities in determining that action is required under the CCS Act, to promote effective communication and collaboration by WACHS in ensuring an unborn child/infant is safe from harm.

- Please note, the Department of Communities' 22 prompts of the Interaction tool and the Casework Practice Manual section 2.2.18 High-risk infants and associated threshold for the Department of Communities in determining that action, is not readily accessible to WACHS staff.

- The WA Health *Guidelines for Protecting Children 2020* has been distributed across WACHS and is used to inform development of WACHS policies, procedures, and protocols.

Other related initiatives

- WACHS is working strategically with the Department of Communities to better identify, protect and care for children at risk of child abuse and neglect.
- WACHS actively participated in a working group to establish a new Memorandum of Understanding (MOU) between the Departments of Health and Communities.
- The MOU was signed in late 2022 and there is a shared plan to update the associated schedules that define specific processes, roles, and responsibilities.
- In the WACHS regions, key staff participate in interagency meetings and communications to monitor local children at risk. Monthly meetings, involving key staff from WACHS, Department of Communities and other agencies relevant to the local communities, operate in most regions. Regular meetings are being reinstated in some areas following service disruptions.
- A Health Navigator Pilot Program is being trialled in the South West and Mirrabooka areas. The aim of the Pilot Program is to design and test new ways of working to improve collaboration and coordination between services to better meet the health needs of children and young people in out of home care in WA.
- WACHS recently established the Engagement procedure for community child health and child development services. This new procedure outlines the responsibilities of staff to provide accessible and equitable services that enhance family engagement. Importantly, it guides staff in situations when non-engagement raises concerns about a child's safety and wellbeing.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 4: The Department of Justice provides the Ombudsman with a report by 30 June 2021, outlining the outcomes of the quality assurance project to assess compliance with Chapter 19 of the Adult Community Corrections Handbook in the management of Community Based Orders to ensure:

- **Referrals are made to Communities where children are at risk;**
- **Proactive information sharing with Communities to protect the safety of an adult victim of family and domestic violence; and**
- **Collaborative case management where continued concerns are held for the safety of children or an adult victim of family and domestic violence.**

Steps taken to give effect to the recommendation

DOJ provided this Office with a letter dated 22 June 2021, in which DOJ relevantly informed this Office that:

> The Department of Justice, Corrective Services, Adult Community Corrections (ACC) utilises an ACC Quality Improvement and Operational Endorsement Framework to provide quality assurance oversight of offender case management practices.

The framework requires ACC team leaders, managers, and directors to regularly undertake a 'sample review' of ACC offender cases, and where necessary provide advice and directions on any actions required to be undertaken. The review and outcomes are recorded in the Department's Community Business Information System (C-BIS) database for the management of offenders in the community.

It is noted for the purpose of this report to the Ombudsman, that monthly data (set out below) is represented in averages for a three-month period up to 1 May 2021. The figures provide an overall number of cases reviewed.

In January 2021, a directive was sent to all ACC managers that (as a part of the above framework) they are to incorporate each of the elements of the Ombudsman's recommendation when reviewing offender cases where children or adult victims of FDV may be at risk. These requirements commenced on 25 January 2021.

For the three-month period up to 1 May 2021, ACC randomly sampled an average of 85 cases per month. For the purpose of the Ombudsman's recommendation, an average of 39 cases (per month) were considered relevant to child and/or adult safety. These were identified from cases managing offenders subject to community supervision orders for offences committed in an FDV context.

To provide a further level of scrutiny, ACC managers are also required to provide a detailed running sheet to the ACC Directorate on a monthly basis of the 'sample cases' reviewed and to include any remedial actions undertaken where necessary.

The above directive was further reinforced with ACC managers at subsequent leadership meetings and the additional level of scrutiny as detailed above will remain in place until further notice.

While the above process has only been in place for a relatively short period of time, it is evident from the sample group that the three elements of the Ombudsman's recommendation where relevant are a focus of case management practices.

It is also evident that ACC is taking relevant remedial action to ensure that case managers submit appropriate referrals to the Department of Communities, and that follow up and engagement with Communities occurs as necessary in the management of the particular case. For the three-month period to 1 May 2021, remedial action was required for an average of 18 cases per month.

ACC will continue to monitor the above process until such time that the Ombudsman's recommendation is embedded in offender case management practices.

DOJ provided this Office with a subsequent letter dated 1 July 2022, in which DOJ relevantly informed this Office that:

- On 22 June 2021, DOJ reported to the Ombudsman on the initial outcomes of the ACC sample review regarding the identification and reporting of child risk factors. For the three months (January 2021 to 1 May 2021) an average of 85 cases per month were randomly sampled and of those an average of 39 cases (per month) were considered relevant to child and/or adult safety. Remedial action by case managers was required for an average of 18 (of the 39) cases (per month) or 46%.
- The review was then extended for 12 months – June 2021 to end May 2022 inclusive – with the results as follows:
    - A total of 1124 cases were randomly sampled representing an average of 94 cases per month.

- Of the 1124 cases, a total of 577 cases (or 51%) were considered relevant to child and/or adult safety (and were identified from cases where the community supervision order was made for a Family Domestic Violence offence).
- Of the 577 FDV cases reviewed, remedial action requiring follow-up with the Department of Communities Child Protection and Family Services (DCPFS) was identified in 117 cases.
  - The total number of cases per month identified as requiring remedial action was approximately 10 (whereas for the initial sample review the number was 18 cases per month).
  - This represents approximately 20% of the cases requiring remedial action (whereas for the initial review nearly half the cases reviewed required remedial action).

- The review results over the past 12 months indicate improved compliance with Chapter 19 of the ACC Handbook, to ensure appropriate information sharing with the Department of Communities where children or adult victims may be at risk.
- The results also indicate the practice of referring and liaising with the Department of Communities and undertaking a collaborative case management approach is being embedded into ACC practice. Consequently, the manual recording for this review exercise will no longer be undertaken.
- The wider 'dip sampling' of ACC cases will continue as part of compliance under the ACC Quality Improvement and Endorsement Framework. This is in addition to the regular review of cases conducted as part of ACC case management practices.

This Office requested that DOJ inform the Office of any further steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 15 March 2023, containing a report prepared by DOJ.

In the DOJ's report, DOJ relevantly informed this Office that:

> Random review is continuing as per the regular 'dip sampling' of cases under the ACC Quality Improvement and Endorsement Framework. This is in addition to the regular review of cases conducted as part of ACC case management practices.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 5: That Communities considers whether any action is required to ensure, when a family arranged placement occurs during a Child Safety Investigation, that action is taken to assess the appropriateness of the family arranged placement in the child's best interests, provide associated safety planning and supports to this placement including consideration of whether a protection order (supervision) is required and reports back to the Ombudsman on the outcome of this consideration by 30 April 2021.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 4 May 2021, in which Communities relevantly informed this Office that:

> Communities' role in family arranged placements.

Where family arranged placements occur during Child Safety Investigations (CSI), Communities actions to consider whether the family arranged placement is in the child's best interests, provide support to families and undertake safety planning to promote children's safety are underpinned by the *Signs of Safety Child Protection Practice Framework (Signs of Safety)*. Mechanisms which further prompt these steps include the provision of the Establishment Payment, which is used by Districts to support family arranged placements with a one-off payment to the family carer. *Casework Practice Manual entry 1.2.3 Establishment payment to informal relative carers* outlines practice guidance which supports child protection workers to consider whether family arrangement placements are in a child's best interests and practice requirements for child protection workers to:

> *undertake a CSI and develop a safety plan with the family using Signs of Safety, taking into consideration the families proposed living arrangement for the child. You must include steps and actions which will be taken if the situation changes after the child moves into the living arrangement for example if the parents withdraw their support of the living arrangement or if the carer is unable or unwilling to continue to provide care for the child.*

Communities is further strengthening assessment and safety planning responses via the *Signs of Safety 100 Days of Trainin*g which includes *Safety Planning Bootcamps* being delivered in every District during 2021. Further to this, the *Signs of Safety Knowledge Hub* supports child protection workers to strengthen safety planning responses.

<u>The use of a Protection Order (Supervision) in a family arranged placement.</u>

Where CSI's are carried out, child protection workers assess the parent's capacity to protect the child and consider whether the child is in need of protection, which includes the use of a Protection Order (Supervision).

In relation to CSI's where a family arranged placement occurs, Section 50(3) of the *Children and Community Services Act 2004* (the Act) sets out that Protection Orders (Supervision) are not to be used to ensure that specified children are cared for by people other than the parent:

> *A protection order (supervision) must not include a condition about -*
>
> *a. The person or persons with whom the child is to live, unless the condition relates to the child living with a parent of the child specified in the order; or*
>
> *b. Who is to have responsibility for the day-to-day care, welfare, and development of the child.*

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023 in which Communities relevantly informed this Office that:

This recommendation has been actioned.

<u>Current Status - Legislation</u>

On 14 October 2021, new child protection laws were passed by the Western Australian Parliament. Most of the amendments in the *Children and Community Services Amendment Act 2021* (Amendment Act) became operational on 19 October 2021. Section 50(3) of the Act now sets out that Protection Orders (Supervision) are not to be used to specify who a child is to live with or who will care for the child:

> *A protection order (supervision) may include a condition requiring the child to live with a specified parent of the child, but otherwise must not include a condition about –*

a. *The person or persons with whom the child is to live; or*

b. *Who is to have responsibility for the day-to-day care, welfare, and development of the child.*

Current status - Safety planning in informal family care arrangements

To strengthen safety planning and culturally responsive practice in Informal Family Care Arrangements, on 21 September 2022 Communities delivered an Informal Family Care Arrangement Practice Clinic, to over 70 attendees. The majority of the attendees were Aboriginal Practice Leaders, Senior Practice Development Officers and Team Leaders.

The focus of the Practice Clinic was the development of robust safety plans, identifying safety networks and discussions on culturally responsive practice in Informal Family Care Arrangements. Discussions were held on the importance of decisions being family led, balanced with Communities' legislative responsibilities and the best interests of the child.

Communities is currently drafting a new CPM entry in relation to Informal Family Care Arrangements and reviewing associated guidance in relation to the Establishment Payment.

Communities is anticipating that further training on Safety Planning will be delivered by Elia International to Communities staff…

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 6: Communities provides a report to the Ombudsman within six months of the finalisation of this child death review outlining actions taken and/or proposed by Communities' 'working party' established to review executive governance and oversight processes for children placed on the Monitored List, inclusive of children not in the Chief Executive Officer's care.

Steps taken to give effect to the recommendation

Communities provided this Office with a letter dated 9 November 2021, in which Communities relevantly informed this Office that:

Communities is committed to reviewing the oversight processes for children placed on the Monitored List.

Communities is taking steps to implement this recommendation through the Reviews and Recommendations Oversight Group (the Oversight Group). Communities recently established the Oversight Group to endorse work packages and have oversight of the implementation of all internal and external recommendations delivered to Communities. The Oversight Group consists of senior officers who represent a cross-section of Communities and hold decision-making authority within their business area.

The Oversight Group has endorsed a problem definition for the Monitored List Review. Problem definitions are the first step to scope one or more recommendations into a service and/or operations improvement-focussed project. Once endorsed, problem definitions are developed into project scopes.

Communities is currently undertaking the scoping for the Monitored List Review project, and this will be presented to the Oversight Group for endorsement. Once the project scope is endorsed, the Oversight Group will allocate the work to a lead business area, which will be responsible for implementing the project and providing regular progress updates.

Communities' letter dated 9 November included a copy of the *Monitored List Review Problem Definition* which had been endorsed by the Oversight Group in September 2021.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> Current Status
>
> Communities recognises that High Risk Infants are particularly vulnerable and must not be placed on the Monitored List. Work to enhance systems to strengthen executive governance and oversight of children placed on the Monitored List and to prevent High Risk Infants from being placed on to Monitored Lists has been undertaken across the agency. This work has included the SRRS driving changes internally within their District and the Community Services Division progressing a broader project in relation to the Monitored List, as part of the Workload Management Project.
>
> Statewide Referral and Response Service
>
> SRRS has taken steps to promote the assessment and identification of High-Risk Infants, including:
>
> - All Interactions where there is FDV and/or a High-Risk Infant now requires a Team Leader consultation before completion, regardless of Interaction outcome (no further action, Intake or Intake to Child Safety Investigation).
> - On 1 March 2023, as part of the Interaction Tool project, the Interaction Tool was embedded into Assist. This change resulted in:
>   - high-risk infant practice guidance is now outlined in the guidance section on the system, which is visible to Child Protection Workers when completing the age section of the Interaction Tool;
>   - the Interaction Tool includes a hyperlink to the High-Risk Infant Checklist, for easy accessibility by Child Protection Workers;
>   - the questions included in the Checklist are included in the suggested questions in the relevant sections of the Interaction Tool;
>   - High-Risk Infants are now identified via a 'tick box' in Interactions. Family groups subject to an intake which include a High-risk Infant now automatically proceed to a Priority-One referral; and
>   - Priority One Child Safety Investigations (CSI's) which include a High-risk Infant are referred to Districts via three channels:
>   1. an email to the District's 'frontdesk' inbox with the details of the case;
>   2. an automated email to the District Director, Assistant District Director and Child Safety Team Leader which alerts them to the new CSI which includes a High-risk infant; and

3. a telephone call from SRRS to the District to confirm that District staff have received the email referrals in relation to new CSI's including High-risk infants.

Community Services Service Design and Operational Improvement

Communities' Community Services Division, in consultation with the Specialist Child Protection Unit, has undertaken steps to review and strengthen processes and systems associated to Workload Management and the Monitored List. This includes:

- A review of the Casework Practice Manual (CPM) entries in relation to the Monitored List.
- On 17 December 2022, the CPM was amended to reflect consistent advice across all entries, that any child under three years of age cannot be placed on the Monitored List. This includes children in the care of the CEO and unborn infants open to Pre-birth planning.
- This change in practice was discussed in District Director, Assistant District Director and Regional Executive Director meetings and communicated via an action bulletin to all practice teams in the Districts.
- To further embed this change in practice, the Workload Management Project Team undertook an audit of all District Monitored Lists and worked with those Districts with higher numbers of children aged under three years of age on the Monitored List to discuss allocation of work, prioritisation, and oversight processes.
- In February and March 2023, the Workload Management Project Team delivered three practice clinics, to discuss case supervision in the context of Workload Management, to educate and support greater oversight of cases on the Monitored List.
- The Workload Management Team have worked with a consultant to develop a trial 'dashboard' to provide Districts with greater visibility and oversight of their caseloads and the ability to readily identify where cases with children aged under three have been placed on a Monitored List. The dashboard clearly highlights these children's details. The dashboard is currently in a testing phase and has not yet been implemented broadly.
- On 9 January 2023, Communities commenced generating an automated email each Monday, which is sent to all District Directors. The email includes information on the individual children and family groups who have been on the Monitored List for more than 14 days, and the length of time the child and family group had been on the List, including children who are aged under three years.
- In addition to the weekly email, a daily report is generated and sent to District Directors, Assistant District Directors, and Team Leaders, which lists all activities where the High-Risk Infant checkbox in Interactions has been ticked.

In March 2023, the Executive Director Service Delivery endorsed a decision for:

- A weekly automated email to be sent to all Regional Executive Directors, commencing 27 March 2023. It is planned for Regional Executive Directors to receive information on this new process, including their role in provision of increased governance of the Monitored List, at the next Regional Executive Directors meeting on 4 April 2023.

- As part of the monthly workload management reporting, a monthly report is generated and made available to Regional Executive Directors, which lists children under three years of age who are on the Monitored List, at the time of the report being run (the first Friday of each month).
- Regional Executive Directors will be responsible for providing feedback to the Executive Director, Community Services regarding the status of each of the cases on the Monitored List involving children under three years of age, within five calendar days of receiving the monthly workload management report data.
- Communities is continuing to explore further options for systems enhancements to align with practice guidance preventing children aged under three years being placed on the Monitored List.

It is noted that these steps taken were also informed by further child death reviews undertaken by this Office in 2022-23 (see Recommendations section).

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

The Office will continue to monitor, and report on, the steps being taken to give effect to the recommendations including through the undertaking of reviews of child deaths, and family and domestic violence fatalities, and in the undertaking of major own motion investigations.

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of child deaths. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2022-23, timely review processes have resulted in 62% of all reviews being completed within six months.

Major Own Motion Investigations Arising from Child Death Reviews

In addition to taking action on individual child deaths, the Office identifies patterns and trends arising out of child death reviews to inform major own motion investigations that examine the practices of public authorities that provide services to children and their families.

Details of own motion investigations are provided in the Own Motion Investigations, Monitoring and Improvement section.

Preventing suicide by children and young people 2020

About the report

As part of the Ombudsman's responsibility to review the deaths of Western Australian children, on 24 September 2020, *Preventing suicide by children and young people 2020* was tabled in Parliament. The report is comprised of three volumes:

- Volume 1 an executive summary;

- Volume 2 an examination of the steps taken to give effect to the recommendations arising from the report of the Ombudsman's 2014 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (**the 2014 Investigation**); and
- Volume 3, the report of the Ombudsman's 2020 major own motion investigation, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people* (**the 2020 Investigation**).

Arising from the 2014 Investigation, the Ombudsman made 22 recommendations about ways that State government departments and authorities can prevent or reduce suicide by young people directed to the Mental Health Commission, the (then) Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education broadly aimed at:

- developing differentiated strategies for suicide prevention relevant to each of the four groups of young people who died by suicide for inclusion in the Western Australian Suicide Prevention Strategy (Recommendations 1, 2 and 3);
- improving service delivery and the rate at which operational policy is implemented into practice within the Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education (Recommendations 4 - 21); and
- promoting inter-agency collaboration between the Mental Health Commission, Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education, through consideration of a joint case management approach and shared tools for use with young people experiencing multiple risk factors associated with suicide (Recommendation 22).

Importantly, the Ombudsman also indicated that the Office would actively monitor the implementation of these recommendations and report to Parliament on the results of the monitoring.

Objectives

The objectives of Volume 2 of the September 2020 report *Preventing suicide by children and young people 2020* were to consider (in accordance with the *Parliamentary Commissioner Act 1971*):

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations; or
- If no such steps have been, or are proposed to be taken, the reasons therefore.

Volume 2 also considered whether the steps taken, proposed to be taken or reasons for taking no steps:

- seem to be appropriate; and
- have been taken within a reasonable time of the making of the recommendations.

After reviewing information arising from the reviews of the lives of children and young people who died by suicide following the 2014 Investigation along with current literature on suicide by children and young people, the Ombudsman decided to commence a new own motion investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people.

The objectives of the 2020 Investigation were to:

- further develop and build upon the detailed understanding of the nature and extent of involvement between the children and young people who died by suicide and State government departments and authorities;
- identify any continuing, new or changed patterns and trends in the demographic characteristics and social circumstances of the children and young people who died by suicide; circumstances of the deaths by suicide; risk factors associated with suicide experienced by the children and young people; and their contact with State government departments and authorities; and
- based on this understanding, identify ways that State government departments and authorities can prevent or reduce suicide by children and young people, and make recommendations to these departments and authorities accordingly.

Methodology

As detailed in Volume 2 of the Report, in order to inform its consideration of whether the steps taken to give effect to the recommendations of the 2014 Investigation, the Office:

- sought from the (then) Mental Health Commissioner, the (then) Director General of the Department for Child Protection and Family Support, the Director General of the Department of Health, and the (then) Director General of the Department of Education a report on the steps that had been taken, or were proposed to be taken, to give effect to the recommendations arising from the 2014 Investigation;
- where further information, clarification or validation was required, met with the relevant State government departments and authorities and collected additional information relevant to suicide by young people in Western Australia;
- reviewed and considered the information provided by the Mental Health Commission, the (then) Department for Child Protection and Family Support, the Department of Health and the Department of Education and the additional information, clarification or validation obtained by the Office; together with relevant current national and international literature regarding suicide by children and young people and the associated risk factors;
- developed a draft report;
- provided the draft report to relevant State government departments and authorities for their consideration and response; and
- developed a final report including findings and recommendations.

Additionally, in order to undertake the 2020 Investigation contained in Volume 3 of the Report, the Office:

- conducted a review of relevant national and international literature regarding suicide by children and young people;
- consulted with government and non-government organisations;
- collected data from State government departments and authorities about each of the 79 children and young people who died by suicide during the 2020 Investigation period (**the 79 children and young people**);
- analysed the data relating to the 79 children and young people using qualitative and quantitative techniques to develop draft findings;

- consulted relevant stakeholders regarding the results of the Office's analysis as well as engaging external professionals with expertise regarding suicide by children and young people to critically comment and review the data collection, analysis and draft findings;
- developed a preliminary view and provided it to relevant State government departments and authorities for their consideration and response; and
- developed a final view including findings and recommendations.

Summary of Findings: Giving effect to the recommendations arising from the 2014 Investigation

The Office is very pleased that in relation to all of the recommendations arising from the 2014 Investigation, the Mental Health Commission, Department of Health, Department of Education and the (then) Department for Child Protection and Family Support had either taken steps, or propose to take steps (or both) to give effect to the recommendations. In no instances did the Office find that no steps had been taken to give effect to the recommendations.

As detailed in Volume 2 of the report, of the 25 recommendations arising from the 2014 Investigation:

- three recommendations were directed to the Mental Health Commission and steps have been taken to give effect to all three recommendations;
- five recommendations were directed to the Department of Health and steps have been taken (and in some cases, are also proposed to be taken) to give effect to all five recommendations;
- six recommendations were directed to the (then) Department for Child Protection and Family Support and steps have been taken (and in some cases, are also proposed to be taken) to give effect to four recommendations and steps are proposed to be taken to give effect to two recommendations;
- seven recommendations were directed to the Department of Education and steps have been taken (and in some cases, are also proposed to be taken) to give effect to six recommendations and steps are proposed to be taken to give effect to one recommendation; and
- one recommendation was directed to the Mental Health Commission, working together with the Department of Health, the (then) Department for Child Protection and Family Support and the Department of Education, and steps have been taken to give effect to this recommendation.

Summary of Findings: the 2020 Investigation

Arising from the findings of the 2020 Investigation, the Ombudsman made seven recommendations to four government agencies about preventing suicide by children and young people, including the development of a suicide prevention plan for children and young people to focus and coordinate collaborative and cooperative State Government efforts.

The Ombudsman is very pleased that each agency has agreed to these recommendations and has, more generally, been positively engaged with the 2020 Investigation. These recommendations are notable not by their number, but by the fact that the Ombudsman has sought to make highly targeted, achievable

recommendations regarding critical issues. Further, the Ombudsman has ensured that the recommendations do not duplicate the work of other investigations and inquiries.

The new information gathered, presented and comprehensively analysed in the 2020 Investigation will be, the Ombudsman believes, a very valuable repository of knowledge for government agencies, non-government organisations and other institutions in the vital work that they undertake in developing and assessing the efficacy of future suicide prevention efforts in Western Australia.

Preventing suicide by children and young people is a shared responsibility requiring collaboration, cooperation and a common understanding of past deaths, risk assessment and responsibilities. The complex and dynamic nature of the risk and protective factors associated with suicide requires a varied and localised response, informed by data about self-harm and suicide, and other indicators of vulnerability experienced by our children and young people. Ultimately, suicide by children and young people will not be prevented by a single program, service or agency working in isolation. Preventing suicide by children and young people must be viewed as part of the core, everyday business of each agency working with children and young people.

The 115 children and young people who died by suicide considered as part of the Ombudsman's 2014 and 2020 Investigations will not be forgotten by their parents, siblings, extended family, friends, classmates and communities. The Ombudsman extends his deepest personal sympathy to all that continue to grieve their immeasurable loss.

It is the Ombudsman's sincerest hope that the extensive new information in this report about suicide by children and young people, and its recommendations, will contribute to preventing these most tragic deaths in the future.

The Office will continue to monitor, and report on, the steps being taken to give effect to these recommendations.

The full report, *Preventing suicide by children and young people 2020* is available at: www.ombudsman.wa.gov.au/SuicideByChildrenAndYoungPeopleReport2020.

Monitoring recommendations from major own motion investigations

The Office also actively monitors the steps taken to give effect to recommendations arising from own motion investigations, including:

- *Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004*, which was tabled in Parliament in November 2011;
- *Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths*, which was tabled in Parliament in November 2012;
- *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, which was tabled in Parliament in April 2014;
- *Investigation into ways to prevent or reduce deaths of children by drowning*, which was tabled in Parliament in November 2017; and
- *Preventing suicide by children and young people 2020*, which was tabled in Parliament in September 2020.

Details of the Office's monitoring of the steps taken to give effect to recommendations arising from own motion investigations are provided in the Own Motion Investigations, Monitoring and Improvement section.

Other Mechanisms to Prevent or Reduce Child Deaths

In addition to reviews of individual child deaths and major own motion investigations, the Office uses a range of other mechanisms to improve public administration with a view to preventing or reducing child deaths. These include:

- Assisting public authorities by providing information about issues that have arisen from child death reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of a child or a child's siblings;
- Through working with public authorities and communities where children may be at risk to consider child safety issues and potential areas for improvement, and highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information with other accountability and oversight agencies including Ombudsmen in other States to facilitate consistent approaches and shared learning;
- Engaging with other child death review bodies in Australia and New Zealand through interaction with the Australian and New Zealand Child Death Review and Prevention Group;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of child deaths; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

The Department of Communities

Efficient and effective liaison has been established with Communities to support the child death review process and objectives. Regular liaison occurs at senior executive level, to discuss issues raised in child death reviews and how positive change can be achieved.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with, or deliver services to, children and their families. Important stakeholders with which the Office liaised in 2022-23 as part of the child death review jurisdiction include:

- The Coroner;
- Public authorities that have involvement with children and their families including:
    - Department of Communities;
    - Department of Health;
    - Health Service Providers;

- Department of Education;
- Department of Justice;
- The Mental Health Commission;
- WA Police Force; and
- Other accountability and similar agencies including the Commissioner for Children and Young People and the Office of the Chief Psychiatrist;

- Non-government organisations; and
- Research institutions including universities.

A Memorandum of Understanding has been established by the Ombudsman with the Commissioner for Children and Young People and a letter of understanding has been established with the Coroner.

Aboriginal and regional communities

In 2016, the Ombudsman established a Principal Aboriginal Consultant position to:

- Provide high level advice, assistance and support to the Corporate Executive and to staff conducting reviews and investigations of the deaths of certain Aboriginal children and family and domestic violence fatalities in Western Australia, complaint resolution involving Aboriginal people and own motion investigations; and
- Raise awareness of and accessibility to the Ombudsman's roles and services to Aboriginal communities and support cross cultural communication between Ombudsman staff and Aboriginal people.

In 2022-23, the Ombudsman created a critical new executive position, Assistant Ombudsman Aboriginal Engagement and Collaboration, which was filled by Laurence Riley in August 2022. This is the first time in the fifty year history of the Office that an Assistant Ombudsman position, and member of Corporative Executive, has been dedicated to Aboriginal Western Australians.

Significant work was undertaken throughout 2022-23 to continue to build relationships relating to the child death review jurisdiction with Aboriginal and regional communities, for example by communicating with:

- Key public authorities that work in regional areas;
- Non-government organisations that provide key services, such as health services to Aboriginal people; and
- Aboriginal community members and leaders to increase the awareness of the child death review function and its purpose.

Additional networks and contacts have been established to support effective and efficient child death reviews. This has strengthened the Office's understanding and knowledge of the issues faced by Aboriginal and regional communities that impact on child and family wellbeing and service delivery in diverse and regional communities.

Family and Domestic Violence Fatality Review

Overview

This section sets out the work of the Office in relation to this function. Information on this work has been set out as follows:

- Background;
- The role of the Ombudsman in relation to family and domestic violence fatality reviews;
- The family and domestic violence fatality review process;
- Analysis of family and domestic violence fatality reviews;
- Patterns, trends and case studies relating to family and domestic violence fatality reviews;
- Issues identified in family and domestic violence fatality reviews;
- Recommendations;
- Timely handling of notifications and reviews;
- Major own motion investigations arising from family and domestic violence fatality reviews;
- Other mechanisms to prevent or reduce family and domestic violence fatalities; and
- Stakeholder liaison.

Background

The *National Plan to End Violence against Women and Children 2022-2032* (**the National Plan**), building on the work of the former *National Plan to Reduce Violence against Women and their Children 2010-2022* sets out actions across four domains to end violence:

1. **Prevention** – working to change the underlying social drivers of violence by addressing the attitudes and systems that drive violence against women and children to stop it before it starts.
2. **Early intervention** – identifying and supporting individuals who are at high risk of experiencing or perpetrating violence and prevent it from reoccurring.
3. **Response** – providing services and supports to address existing violence and support victim-survivors experiencing violence, such as crisis support and police

intervention, and a trauma-informed justice system that will hold people who use violence to account.

4. **Recovery and healing** – helping to reduce the risk of re-traumatisation, and supporting victim-survivors to be safe and healthy to be able to recover from trauma and the physical, mental, emotional, and economic impacts of violence.

In Western Australia, the *Annual Action Plan 2009-10*, associated with the *WA Strategic Plan for Family and Domestic Violence 2009-13*, identified a range of strategies to reduce family and domestic violence including a 'capacity to systematically review family and domestic violence deaths and improve the response system as a result' (page 2). The *Annual Action Plan 2009-10* set out 10 key actions to progress the development and implementation of the integrated response in 2009-10, including the need to '[r]esearch models of operation for family and domestic violence fatality review committees to determine an appropriate model for Western Australia' (page 2).

Following a Government working group process examining models for a family and domestic violence fatality review process, the Government requested that the Ombudsman undertake responsibility for the establishment of a family and domestic violence fatality review function.

On 1 July 2012, the Office commenced its family and domestic violence fatality review function.

In 2017, the State Government released the *Stopping Family and Domestic Violence Policy*, which set out 21 new initiatives for responding to family and domestic violence. This document superseded *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities* (**former State Strategy**) and the *Freedom from Fear Action Plan 2015*. Also in 2017, the first Minister for the Prevention of Family and Domestic Violence was appointed. In July 2020, the Department of Communities (**Communities**) released *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030* (**State Strategy**) and the associated *First Action Plan 2020-2022* (**First Action Plan**). The State Strategy's stated purpose is to 'guide a whole-of-community response to family and domestic violence in Western Australia from 2020-2030' and sets out the following guiding principles:

- People in Western Australia should be safe in their relationships and their homes;
- The safety and wellbeing of victims is the first priority;
- Children and young people exposed to domestic violence are victims;
- Perpetrators are solely responsible for their actions – victims must not be blamed;
- Women's safety is linked to gender equality;
- Everyone has a role in stopping family and domestic violence;
- Effective solutions are locally tailored, culturally safe and trauma informed;
- Men and boys are integral to the solution; and
- There is 'no wrong door approach' to service delivery.

The Ombudsman's family and domestic violence fatality reviews examine stakeholder implementation of the State Strategy, to prevent or reduce the risks associated with family and domestic violence fatalities.

It is essential to the success of the family and domestic violence fatality review role that the Office identified and engaged with a range of key stakeholders in the implementation and ongoing operation of the role. It is important that stakeholders

understand the role of the Ombudsman, and the Office understands the critical work of all key stakeholders.

Working arrangements have been established to support implementation of the role with the Western Australia Police Force (**WA Police Force**) and Communities and with other agencies, such as the Department of Justice (**DOJ**) and relevant courts.

Through regular liaison with key stakeholders, the Office gains valuable information to ensure its review processes are timely, effective and efficient.

The Office has also accepted invitations to speak at relevant seminars and events to explain its role in regard to family and domestic violence fatality reviews and since 1 July 2012, has participated as a Member of the Australian Domestic and Family Violence Death Review Network.

The Role of the Ombudsman in Relation to Family and Domestic Violence Fatality Reviews

Information regarding the use of terms

Information in relation to those fatalities that are suspected by WA Police Force to have occurred in circumstances of family and domestic violence are described in this report as family and domestic violence fatalities. For the purposes of this report the person who has died due to suspected family and domestic violence will be referred to as 'the person who died' and the person whose actions are suspected of causing the death will be referred to as the 'suspected perpetrator' or, if the person has been convicted of causing the death, 'the perpetrator'.

Additionally, following Coronial and criminal proceedings, it may be necessary to adjust relevant previously reported information if the outcome of such proceedings is that the death did not occur in the context of a family and domestic relationship.

WA Police Force informs the Office of all family and domestic violence fatalities and provides information about the circumstances of the death together with any relevant information of prior WA Police Force contact with the person who died and the suspected perpetrator. A family and domestic violence fatality involves persons apparently in a 'family relationship' as defined by section 4 of the *Restraining Orders Act 1997*.

More specifically, the relationship between the person who died and the suspected perpetrator is a relationship between two people:

(a) Who are, or were, married to each other; or

(b) Who are, or were, in a de facto relationship with each other; or

(c) Who are, or were, related to each other; or

(d) One of whom is a child who —

  (i) Ordinarily resides, or resided, with the other person; or

  (ii) Regularly resides or stays, or resided or stayed, with the other person; or

(e) One of whom is, or was, a child of whom the other person is a guardian; or

(f) Who have, or had, an intimate personal relationship, or other personal relationship, with each other; or

(g) One of whom is the former spouse or former de facto partner of the other person's current spouse or current de facto partner.

'Other personal relationship' means a personal relationship of a domestic nature in which the lives of the persons are, or were, interrelated and the actions of one person affects, or affected the other person.

'Related', in relation to a person, means a person who —

(a) Is related to that person taking into consideration the cultural, social or religious backgrounds of the 2 persons; or

(b) Is related to the person's —

(i) Spouse or former spouse; or

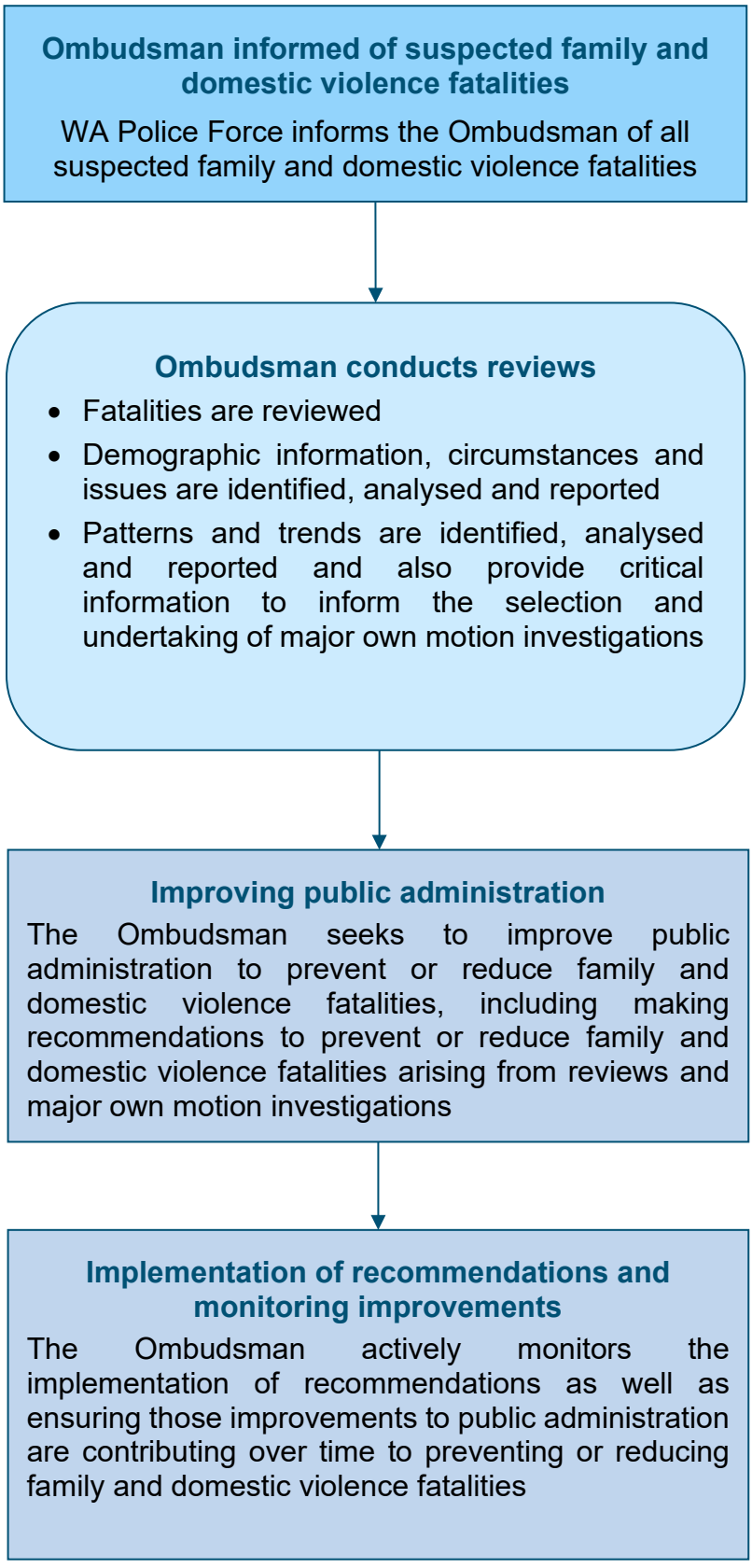
(ii) De facto partner or former de facto partner.

If the relationship meets these criteria, a review is undertaken. A review may also be undertaken where a fatality occurs in the circumstances of family and domestic violence.

The extent of a review depends on a number of factors, including the circumstances surrounding the death and the level of involvement of relevant public authorities in the life of the person who died or other relevant people in a family and domestic relationship with the person who died, including the suspected perpetrator. Confidentiality of all parties involved with the case is strictly observed.

The family and domestic violence fatality review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities. The review does not set out to establish the cause of death of the person who died; this is properly the role of the Coroner. Nor does the review seek to determine whether a suspected perpetrator has committed a criminal offence; this is only a role for a relevant court.

The Family and Domestic Violence Fatality Review Process



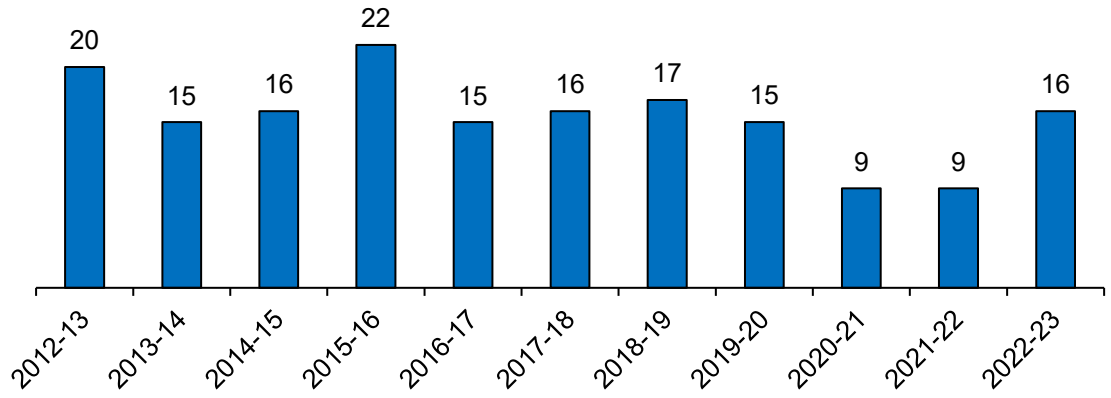
Analysis of Family and Domestic Violence Fatality Reviews

By reviewing family and domestic violence fatalities, the Ombudsman is able to identify, record and report on a range of information and analysis, including:

- The number of family and domestic violence fatality reviews;
- Demographic information identified from family and domestic violence fatality reviews;
- Circumstances in which family and domestic violence fatalities have occurred; and
- Patterns, trends and case studies relating to family and domestic violence fatality reviews.

Number of family and domestic violence fatality reviews

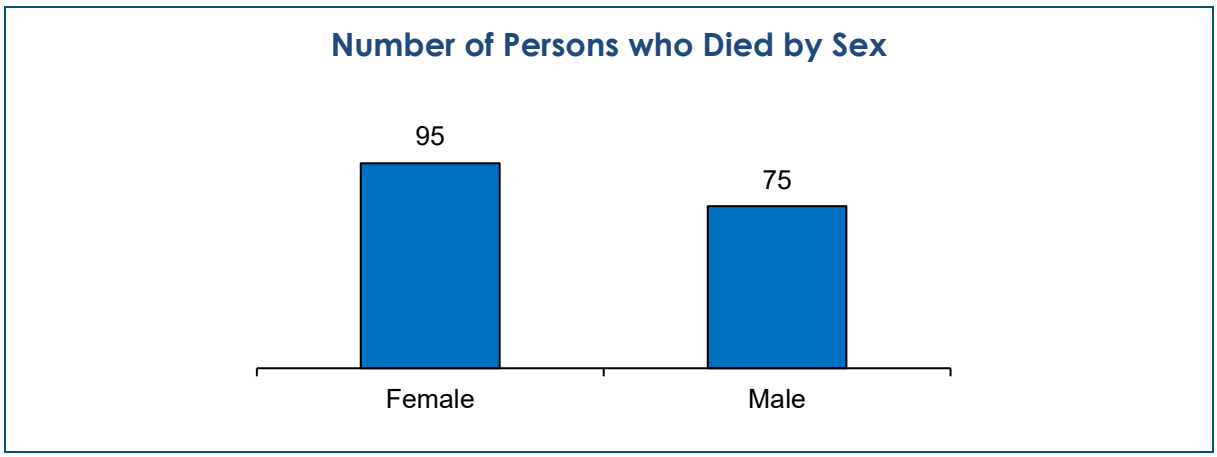
In 2022-23, the number of reviewable family and domestic violence fatalities received was 16, compared to nine in 2021-22, nine in 2020-21, 15 in 2019-20, 17 in 2018-19, 16 in 2017-18, 15 in 2016-17, 22 in 2015-16, 16 in 2014-15, 15 in 2013-14 and 20 in 2012-13.

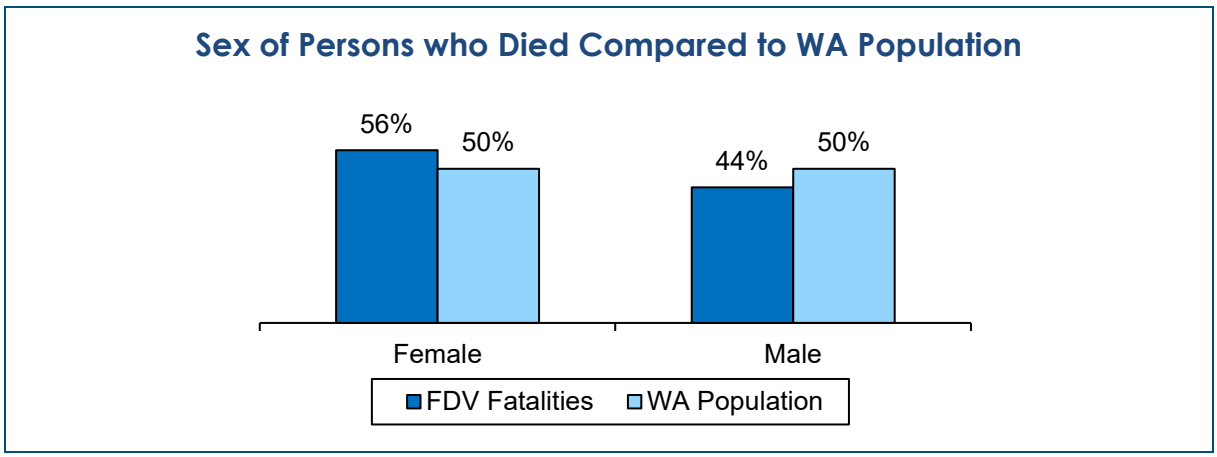


Demographic information identified from family and domestic violence fatality reviews

Information is obtained on a range of characteristics of the person who died, including sex, age group, Aboriginal status, and location of the incident in the metropolitan or regional areas.

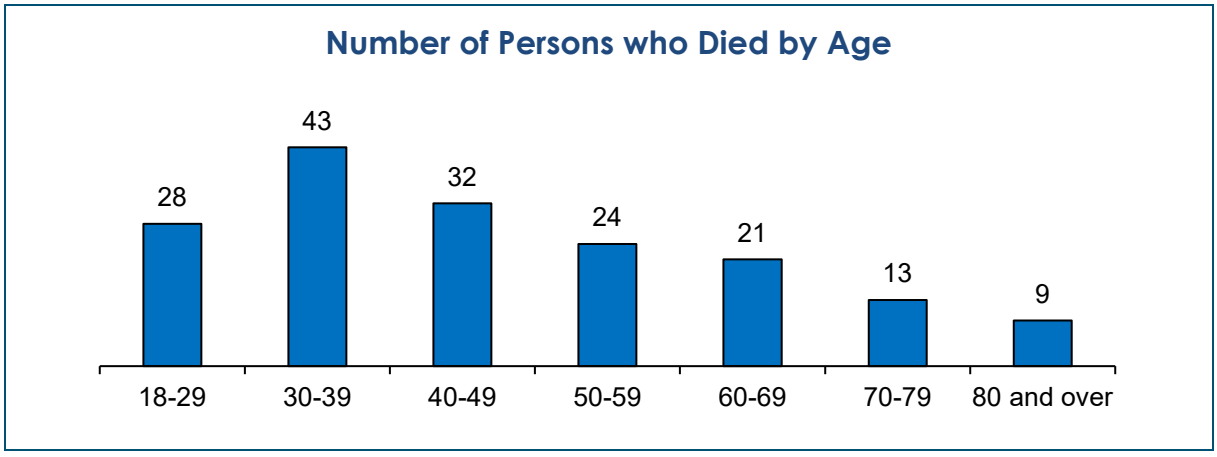
The following charts show characteristics of the persons who died for the 170 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2023. The numbers may vary from numbers previously reported as, during the course of the period, further information may become available.

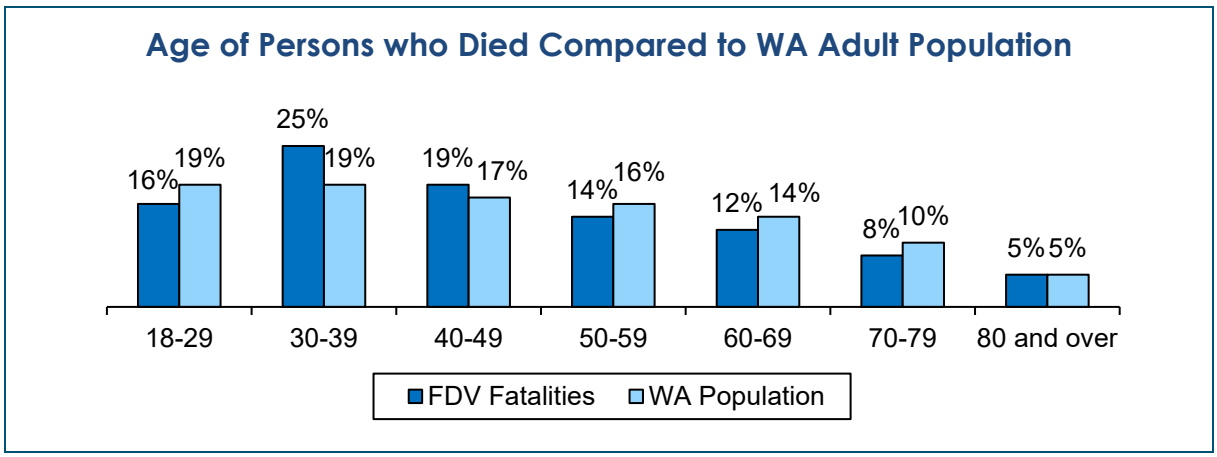




Information is collated on the sex of the deceased, and the suspected perpetrator, as identified in agency documentation provided to this Office. Compared to the Western Australian population, females who died in the 11 years from 1 July 2012 to 30 June 2023 were over-represented, with 56% of persons who died being female compared to 50% in the population.

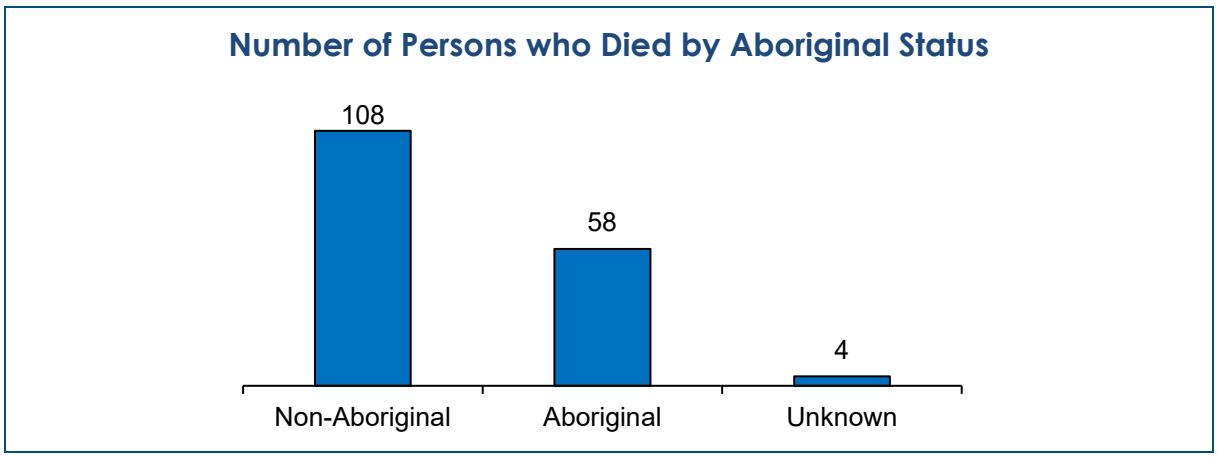
In relation to the 95 females who died, 88 involved a male suspected perpetrator. Of the 75 men who died, 14 were apparent suicides, 28 involved a female suspected perpetrator, 29 involved a male suspected perpetrator and four involved multiple suspected perpetrators of both sexes.

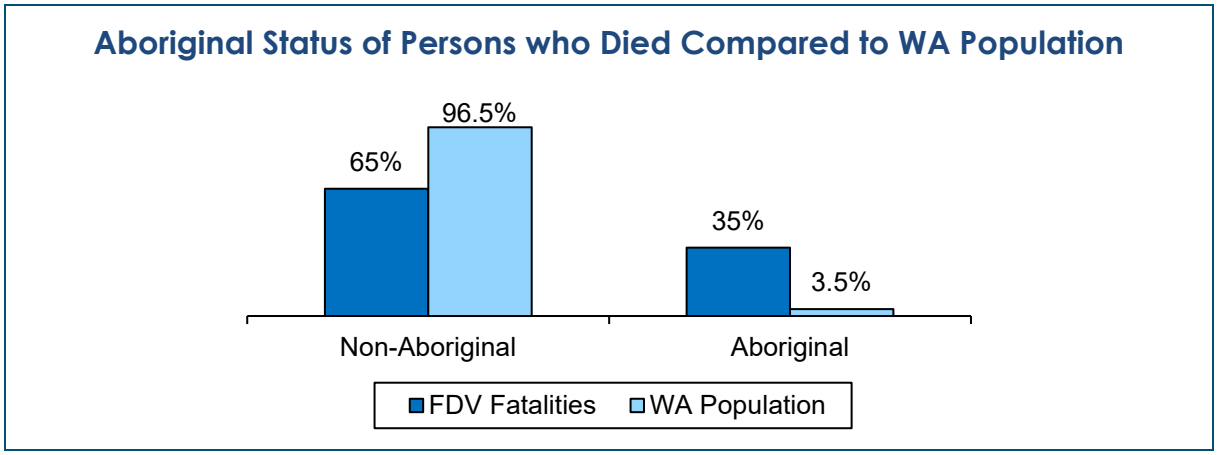




Note: Percentages may not add to 100% due to rounding.

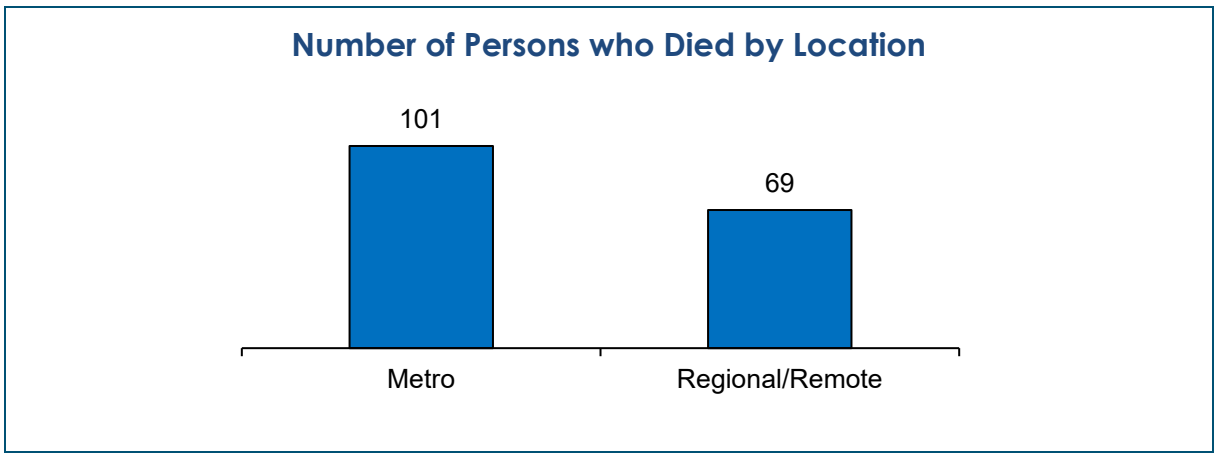
Compared to the Western Australian adult population, the age groups 30-39 and 40-49 are over-represented, with 25% of persons who died being in the 30-39 age group compared to 19% of the adult population, and 19% of persons who died being in the 40-49 age group compared to 17% of the adult population.

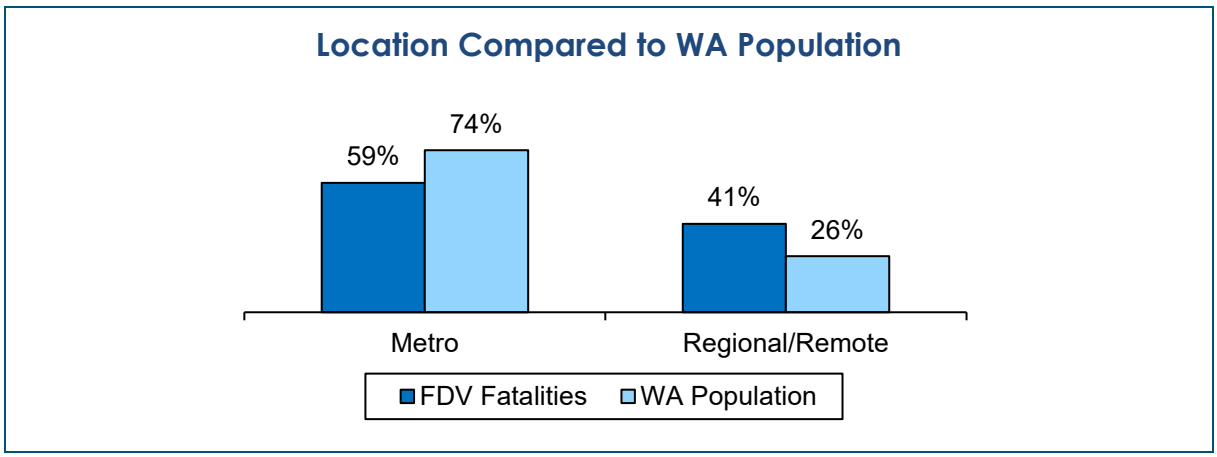




Note: In the above chart, percentages are based on those where Aboriginal status is known.

Information on Aboriginal status is collated where the deceased, and suspected perpetrator, identify as Aboriginal to agencies they have contact with, and this is recorded in the documentation provided to this Office. Compared to the Western Australian population, Aboriginal people who died were over-represented, with 35% of people who died in the 11 years from 1 July 2012 to 30 June 2023 being Aboriginal compared to 3.5% in the population. Of the 54 Aboriginal people who died, 35 were female and 23 were male.





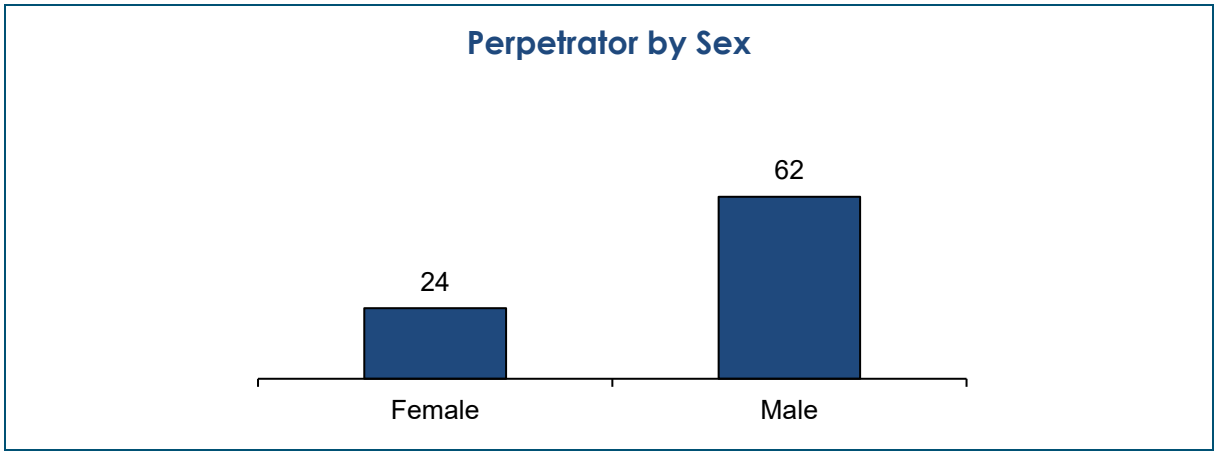
Compared to the Western Australian population, fatalities of people living in regional or remote locations were over-represented, with 41% of the people who died in the 11 years from 1 July 2012 to 30 June 2023 living in regional or remote locations, compared to 26% of the population living in those locations.

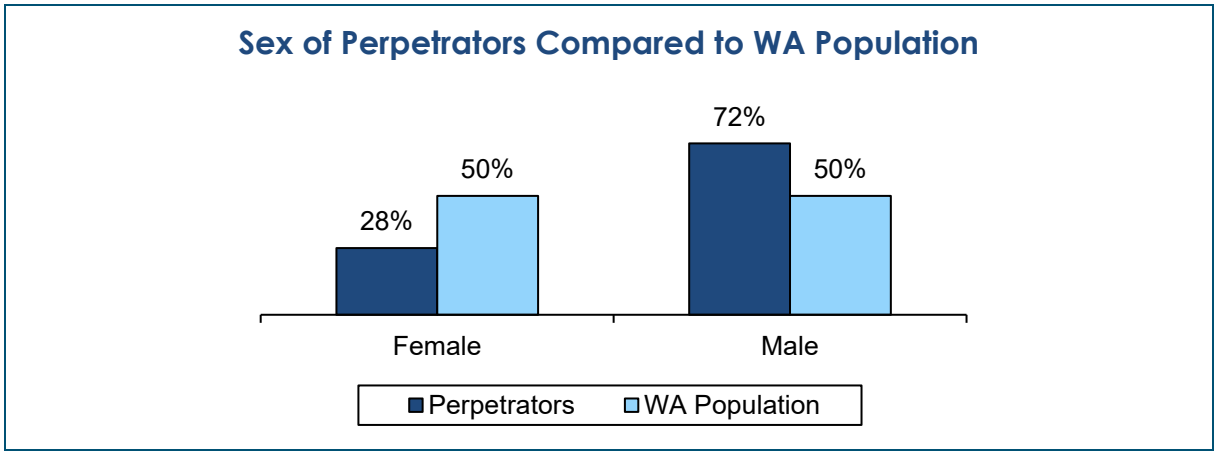
In its work, the Office is placing a focus on ways that public authorities can prevent or reduce family and domestic violence fatalities for women, including Aboriginal women. In undertaking this work, specific consideration is being given to issues relevant to regional and remote Western Australia.

Information in the following section relates only to family and domestic violence fatalities reviewed from 1 July 2012 to 30 June 2023 where coronial and criminal proceedings (including the appellate process, if any) were finalised by 30 June 2023.

Of the 170 family and domestic violence fatalities received by the Ombudsman from 1 July 2012 to 30 June 2023, coronial and criminal proceedings were finalised in relation to 86 perpetrators.

Information is obtained on a range of characteristics of the perpetrator including sex, age group and Aboriginal status. The following charts show characteristics for the 86 perpetrators where both the coronial process and the criminal proceedings have been finalised.

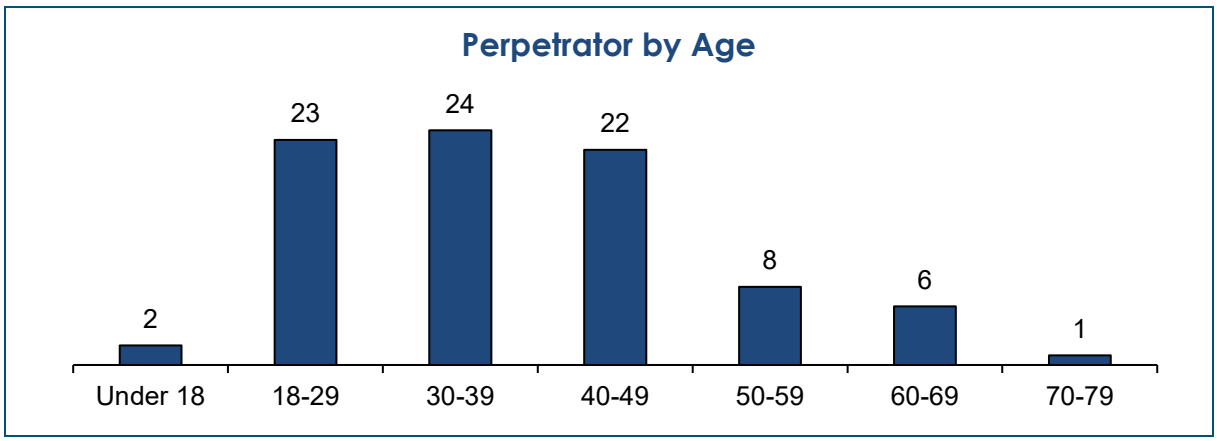


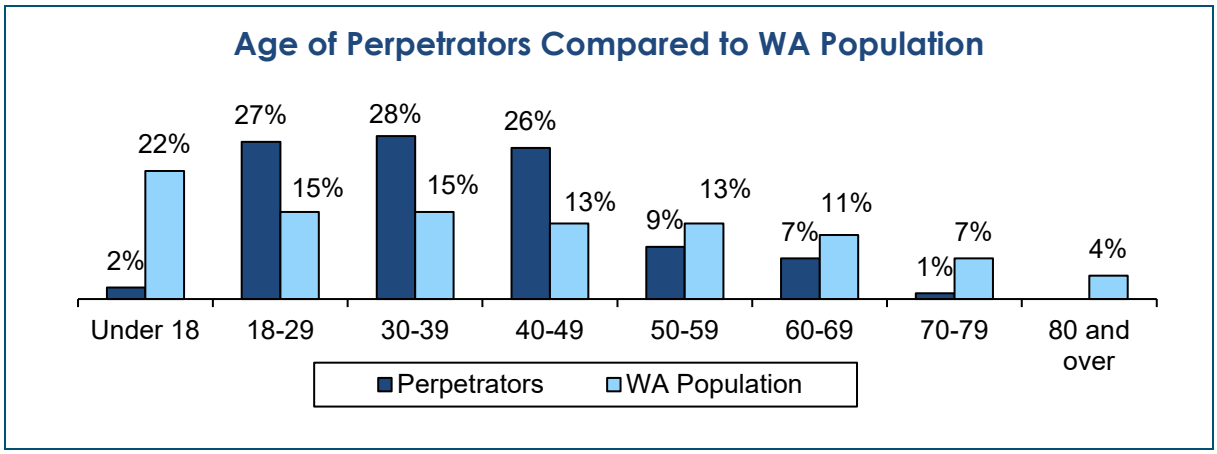


Compared to the Western Australian population, male perpetrators of fatalities in the 11 years from 1 July 2012 to 30 June 2023 were over-represented, with 72% of perpetrators being male compared to 50% in the population.

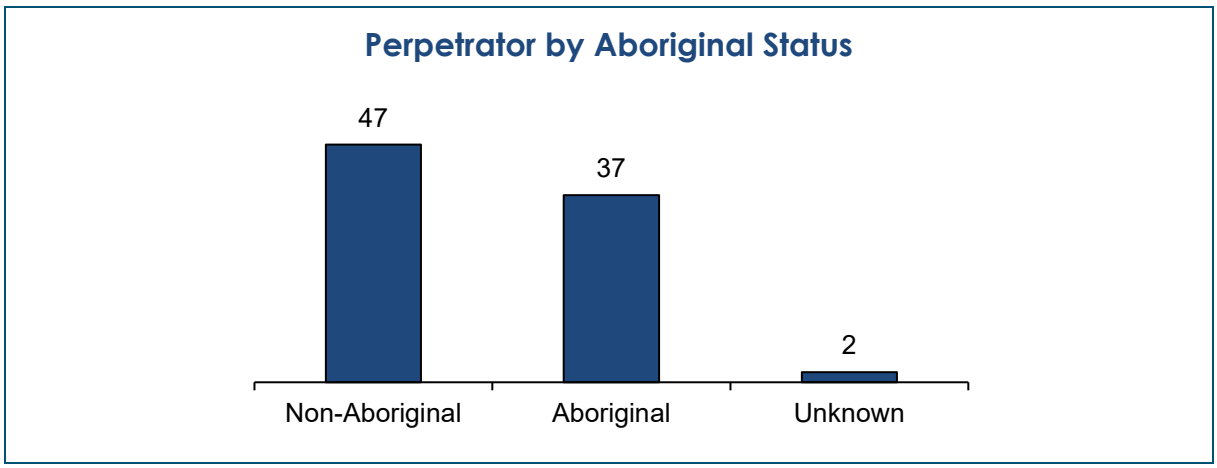
Nineteen males were convicted of manslaughter and 43 males were convicted of murder. Eleven females were convicted of manslaughter, one female was convicted of unlawful assault occasioning death and 12 females were convicted of murder.

Of the 23 fatalities by the 24 female perpetrators, in 22 fatalities the person who died was male, and in one fatality the person who died was female. Of the 63 fatalities by the 62 male perpetrators, in 47 fatalities the person who died was female, and in 16 fatalities the person who died was male.

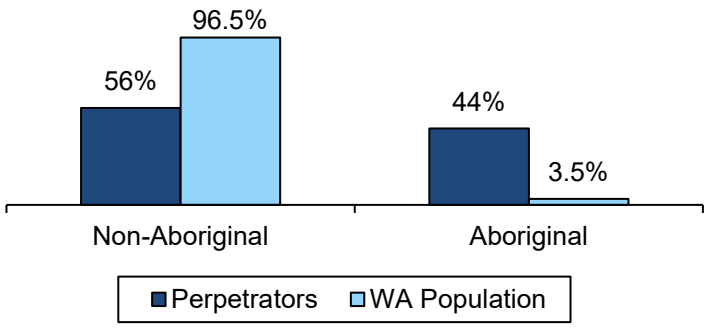




Compared to the Western Australian population, perpetrators of fatalities in the 11 years from 1 July 2012 to 30 June 2023 in the 18-29, 30-39 and 40-49 age groups were over-represented, with 27% of perpetrators being in the 18-29 age group compared to 15% in the population, 28% of perpetrators being in the 30-39 age group compared to 15% in the population, and 26% of perpetrators being in the 40-49 age group compared to 13% in the population.



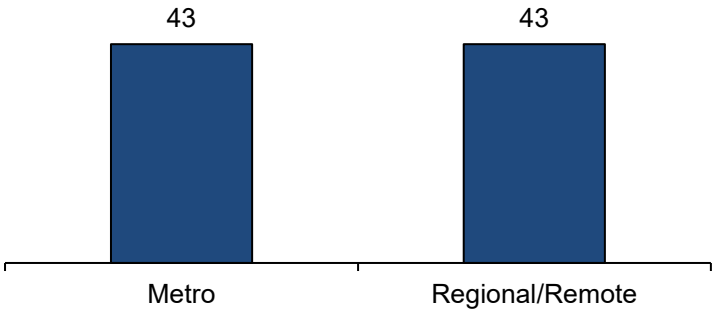
Aboriginal Status of Perpetrators Compared to WA Population



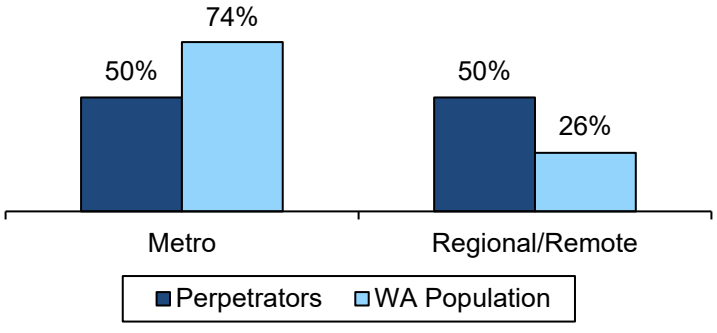
Compared to the Western Australian population, Aboriginal perpetrators of fatalities in the 11 years from 1 July 2012 to 30 June 2023 were over-represented with 44% of perpetrators (where Aboriginal status was recorded in information provided to this Office) being Aboriginal compared to 3.5% in the population.

In 35 of the 37 cases where the perpetrator was Aboriginal, the person who died was also Aboriginal.

Perpetrator by Location



Perpetrators by Location Compared to WA Population



Compared to the Western Australian population, of the 86 fatalities from 1 July 2012 to 30 June 2023 for which coronial and criminal proceedings were finalised, regional or remote locations were over-represented, with 50% of the fatal incidents occurring in regional or remote locations compared to 26% of the population living in those locations.

Circumstances in which family and domestic violence fatalities have occurred

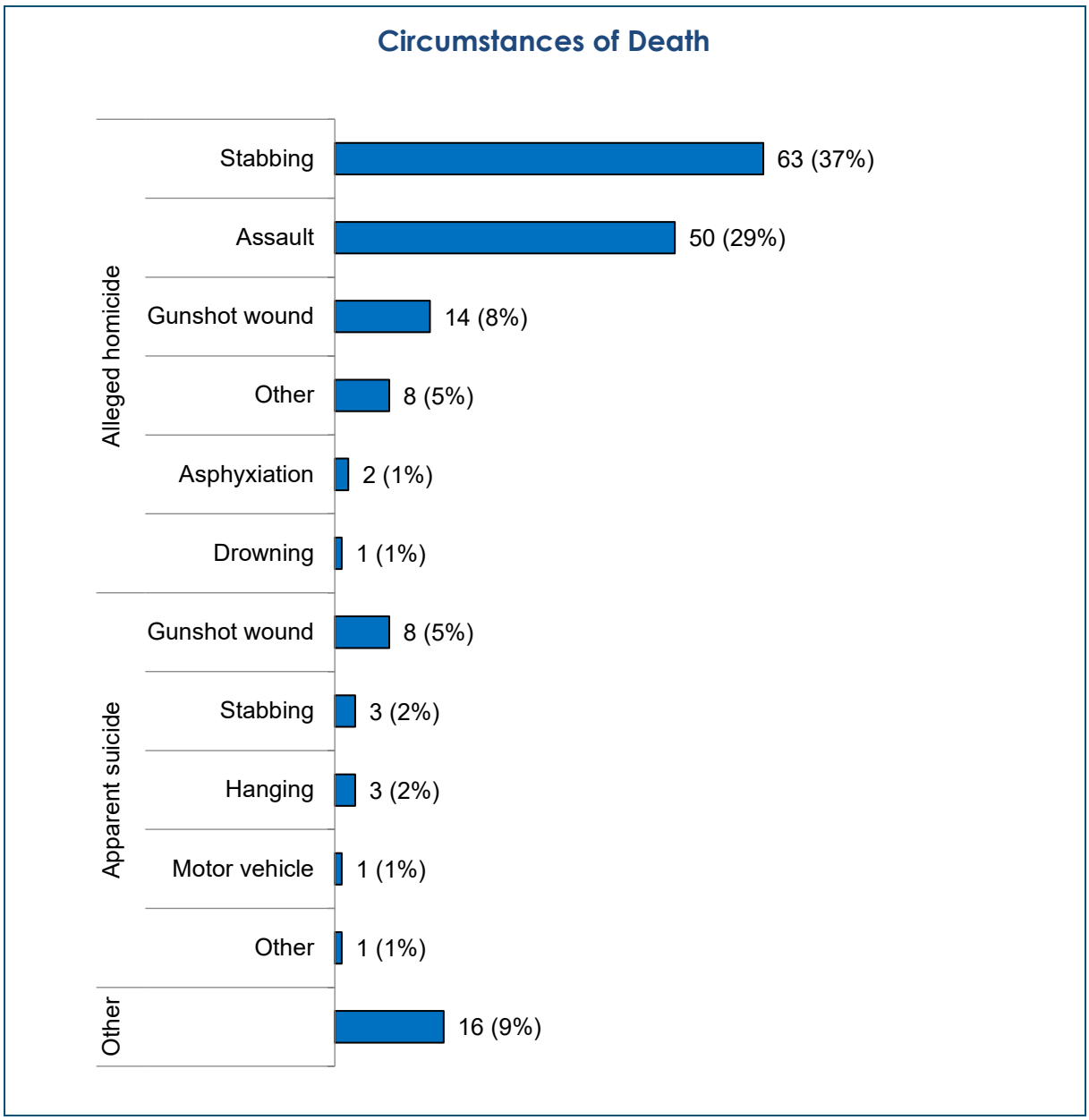
Information provided to the Office by WA Police Force about family and domestic violence fatalities includes general information on the circumstances of death. This is an initial indication of how the death may have occurred but is not the cause of death, which can only be determined by the Coroner.

Family and domestic violence fatalities may occur through alleged homicide, apparent suicide or other circumstances:

- Alleged homicide includes:
  - Stabbing;
  - Physical assault;
  - Gunshot wound;
  - Asphyxiation/suffocation;
  - Drowning; and
  - Other.
- Apparent suicide includes:
  - Gunshot wound;
  - Overdose of prescription or other drugs;
  - Stabbing;
  - Motor vehicle accident;
  - Hanging;
  - Drowning; and
  - Other.
- Other circumstances includes fatalities not in the circumstances of death of either alleged homicide or apparent suicide.

The principal circumstances of death in 2022-23 were alleged homicide by physical assault and stabbing.

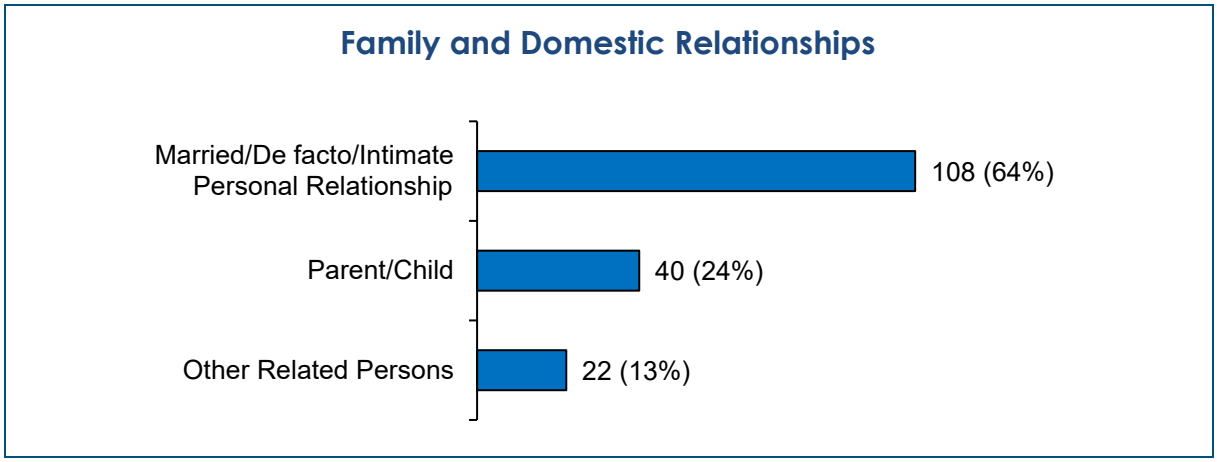
The following chart shows the circumstance of death as categorised by the Ombudsman for the 170 family and domestic violence fatalities received by the Office between 1 July 2012 and 30 June 2023.



Note: Percentages may not add to 100% due to rounding.

Family and domestic relationships

As shown in the following chart, married, de facto, or intimate personal relationship are the most common relationships involved in family and domestic violence fatalities.



Note: Percentages may not add to 100% due to rounding.

Of the 170 family and domestic violence fatalities received by the Office from 1 July 2012 to 30 June 2023:

- 108 fatalities (64%) involved a married, de facto or intimate personal relationship, of which there were 90 alleged homicides, 12 apparent suicides and six in other circumstances. The 108 fatalities included 20 deaths that occurred in 10 cases of alleged homicide/suicide and, in all 10 cases, a female was allegedly killed by a male, who subsequently died in circumstances of apparent suicide. Of the other two apparent suicides, one involved a male and one involved a female. Of the remaining 80 alleged homicides, 56 (70%) of the people who died were female and 24 (30%) were male;
- 40 fatalities (24%) involved a relationship between a parent and adult child, of which there were 28 alleged homicides, four apparent suicides and eight in other circumstances. Of the 28 alleged homicides, 11 (39%) of the people who died were female and 17 (61%) were male. Of these 28 fatalities, in 21 cases (75%) the person who died was the parent or step-parent and in seven cases (25%) the person who died was the adult child or step-child; and
- There were 22 people who died (13%) who were otherwise related to the suspected perpetrator (including siblings and extended family relationships). Of these, eight (36%) were female and 14 (64%) were male.

Patterns, Trends and Case Studies Relating to Family and Domestic Violence Fatality Reviews[2]

State policy and planning to reduce family and domestic violence fatalities

The State Strategy states 'Communities is the lead agency coordinating strategy and policy direction in prevention of family and domestic violence in Western Australia'. Communities has now established, within its organisation, the Office for Prevention of Family and Domestic Violence to 'elevate the profile of family and domestic violence and provide the stewardship needed within Communities and across government to deliver improved outcomes in the areas of primary prevention, Aboriginal family safety, victim survivor safety and perpetrator accountability' (Department of Communities).

The Ombudsman's family and domestic violence fatality reviews and the Ombudsman's major own motion investigation, *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have identified that there is scope for State Government departments and authorities to improve the ways in which they respond to family and domestic violence. In the report, the Ombudsman recommended that:

> Recommendation 1: DCPFS, as the lead agency responsible for family and domestic violence strategy planning in Western Australia, in the development of Action Plans under *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, identifies actions for achieving its agreed Primary State Outcomes, priorities among these actions, and allocation of responsibilities for these actions to specific state government departments and authorities.

[2] In this section, DCPFS refers to the (then) Department of Child Protection and Family Support (now Communities), DOTAG refers to the (then) Department of the Attorney General (now DOJ) and WAPOL refers to (then) Western Australia Police (now the Western Australia Police Force).

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that steps have been taken to give effect to the Ombudsman's recommendation. Subsequent to this recommendation, the First Action Plan, to be implemented between July 2020 and June 2022, was released with the State Strategy. This Office will continue to monitor implementation of the First Action Plan, and subsequent Action Plans, in family and domestic violence fatality reviews.

Type of relationships

The Ombudsman finalised 160 family and domestic violence fatality reviews from 1 July 2012 to 30 June 2023.

For 101 (63%) of the finalised reviews of family and domestic violence fatalities, the fatality occurred between persons who, either at the time of death or at some earlier time, had been involved in a married, de facto or other intimate personal relationship. For the remaining 59 (37%) of the finalised family and domestic violence fatality reviews, the fatality occurred between persons where the relationship was between a parent and their adult child or persons otherwise related (such as siblings and extended family relationships).

These two groups will be referred to as 'intimate partner fatalities' and 'non-intimate partner fatalities'.

For the 160 finalised reviews, the circumstances of the fatality were as follows:

- For the 101 intimate partner fatalities, 83 were alleged homicides, 12 were apparent suicides, and six were other circumstances; and
- For the 59 non-intimate partner fatalities, 46 were alleged homicides, three were apparent suicides, and 10 were other circumstances.

Intimate partner relationships

Of the 83 intimate partner relationship fatalities involving alleged homicide:

- There were 61 fatalities where the person who died was female and the suspected perpetrator was male, 18 where the person who died was male and the suspected perpetrator was female, one where the person who died was male and the suspected perpetrator was male, and three where the person who died was male and there were multiple suspected perpetrators of both sexes;
- There were 32 fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator. In 21 of these fatalities the person who died was female and in 11 the person who died was male;
- There were 41 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 14 at the residence of the person who died or the residence of the suspected perpetrator, eight at the residence of family or friends, and 20 at the workplace of the person who died or the suspected perpetrator or in a public place; and
- There were 40 fatalities where the person who died lived in regional and remote areas, and in 30 of these the person who died was Aboriginal.

Non-intimate partner relationships

Of the 59 non-intimate partner fatalities, there were 39 fatalities involving a parent and adult child and 20 fatalities where the parties were otherwise related.

Of the 46 non-intimate partner fatalities involving alleged homicide:

- There were 14 fatalities where the person who died was female and the suspected perpetrator was male, three where the person who died was female and the suspected perpetrator was female, 23 where the person who died was male and the suspected perpetrator was male, and six where the person who died was male and the suspected perpetrator was female;
- There were 13 non-intimate partner fatalities that involved Aboriginal people as both the person who died and the suspected perpetrator;
- There were 18 fatalities that occurred at the joint residence of the person who died and the suspected perpetrator, 19 at the residence of the person who died or the residence of the suspected perpetrator, and nine at the residence of family or friends or in a public place; and
- There were 19 fatalities where the person who died lived in regional and remote areas.

Prior reports of family and domestic violence

Intimate partner fatalities were more likely than non-intimate partner fatalities to have involved previous reports of alleged family and domestic violence between the parties. In 48 (58%) of the 83 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2023, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In 17 (37%) of the 46 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2023, alleged family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities.

Collation of data to build our understanding about communities who are over-represented in family and domestic violence

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, found that the research literature identifies that there are higher rates of family and domestic violence among certain communities in Western Australia. However, there are limitations to the supporting data, resulting in varying estimates of the numbers of people in these communities who experience family and domestic violence and a limited understanding of their experiences.

Of the 65 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, from the records available:

- Four (6%) fatalities involved a deceased person with disability;
- None of the fatalities involved a deceased person in a same-sex relationship with the suspected perpetrator;
- 37 (57%) fatalities involved a deceased Aboriginal person; and
- 35 (54%) of the people who died lived in regional/remote Western Australia.

Examination of the family and domestic violence fatality review data provides some insight into the issues relevant to these communities. However, these numbers are limited and greater insight is only possible through consideration of all reported family and domestic violence, not just where this results in a fatality. The report found that neither the former State Strategy nor the *Achievement Report to 2013* identified any actions to improve the collection of data relating to different communities experiencing higher rates of family and domestic violence, for example through the collection of cultural, demographic and socioeconomic data. In the report, the Ombudsman recommended that:

> Recommendation 2: In developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS collaborates with WAPOL, DOTAG and other relevant agencies to identify and incorporate actions to be taken by state government departments and authorities to collect data about communities who are overrepresented in family and domestic violence, to inform evidence-based strategies tailored to addressing family and domestic violence in these communities.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that steps have been taken, and are proposed to be taken, to give effect to this recommendation.

Subsequent to this recommendation, Action Item 4 of the First Action Plan intends to '[d]evelop a family and domestic violence dashboard that tracks and reports demand data, to support monitoring and analysis of current and emerging data trends and inform planning'. In relation to data collation about communities over-represented in family and domestic violence, and how this is used to inform evidence-based strategies tailored to addressing family and domestic violence in these communities, the Ombudsman will continue to monitor the implementation and effectiveness of the State Strategy, and First Action Plan for responding to Aboriginal family violence.

Identification of family and domestic violence incidents

Of the 65 family and domestic violence fatalities involving alleged homicide where there had been prior reports of alleged family and domestic violence between the parties, WA Police Force was the agency to receive the majority of these reports. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, noted that DCPFS may become aware of family and domestic violence through a referral to DCPFS and subsequent assessment through the duty interaction process. Identification of family and domestic violence is integral to the agency being in a position to implement its family and domestic violence policy and processes to address perpetrator accountability and promote victim safety and support. However, the Ombudsman's reviews and own motion investigations continue to identify missed opportunities to identify, and respond to, family and domestic violence in interactions.

In the report, the Ombudsman made two recommendations (Recommendations 7 and 39) that WA Police Force and DCPFS ensure all reported family and domestic violence is correctly identified and recorded. *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that WA Police Force and DCPFS had proposed steps to be taken to give effect to these recommendations. The Office will continue to monitor, and report on, the steps being taken to improve identification, recording and reporting by WA Police Force and Communities of family and domestic violence.

Provision of agency support to obtain a violence restraining order

Prior to 1 July 2017 in Western Australia, a person who experienced domestic violence by another person, whether or not they were related, could apply to the Magistrates Court for a protection order being a violence restraining order. In July 2017, family violence restraining orders were introduced in Western Australia. A family violence restraining order is governed under the *Restraining Orders Act 1997* and can be used to 'restrain' a 'family member' as defined by the *Restraining Orders Act 1997*.

As identified above, WA Police Force is likely to receive the majority of reports of family and domestic violence. WA Police Force attendance at the scene affords WA Police Force with the opportunity to provide victims with information and advice about:

- What a family violence restraining order is and how it can enhance their safety;
- How to apply for a family violence restraining order; and
- What support services are available to provide further advice and assistance with obtaining a family violence restraining order, and how to access these support services.

Support to victims in reported incidences of family and domestic violence

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined WA Police Force's response to family and domestic violence incidents through the review of 75 Domestic Violence Incident Reports (associated with 30 fatalities). The report found that WA Police Force recorded the provision of information and advice about violence restraining orders in 19 of the 75 (25%) instances. In the report, the Ombudsman recommended that:

> Recommendation 9: WAPOL amends the *Commissioner's Operations and Procedures Manual* to require that victims of family and domestic violence are provided with verbal information and advice about violence restraining orders in all reported instances of family and domestic violence.
>
> Recommendation 10: WAPOL collaborates with DCPFS and DOTAG to develop an 'aide memoire' that sets out the key information and advice about violence restraining orders that WAPOL should provide to victims of all reported instances of family and domestic violence.
>
> Recommendation 11: WAPOL collaborates with DCPFS and DOTAG to ensure that the 'aide memoire', discussed at Recommendation 10, is developed in consultation with Aboriginal people to ensure its appropriateness for family violence incidents involving Aboriginal people.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that WA Police Force had taken steps and/or proposed steps to be taken to give effect to these recommendations. Subsequent to these recommendations, Action Item 13(d) of the First Action Plan indicates the WA Police Force intends to undertake 'comprehensive family violence training that is reported in the WA Police Force Annual Report'. In 2020, WA Police Force introduced body worn cameras for use by police and it is now mandatory for body worn cameras to be activated when attending a family and domestic violence incident. This Office is now able to access video from body worn camera to examine police responses to family and domestic violence, including the provision of information of family violence restraining orders. The Office will continue to monitor, and report on,

the provision, by WA Police Force, of information and advice regarding family violence restraining orders.

Support to obtain a violence restraining order on behalf of children

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, also examined the response by DCPFS to prior reports of family and domestic violence involving 30 children who experienced family and domestic violence associated with the 30 fatalities. The report found that DCPFS did not provide any active referrals for legal advice or help from an appropriate service to obtain a violence restraining order for any of the children involved in the 30 fatalities. In the report, the Ombudsman recommended that:

> Recommendation 44: DCPFS complies with the requirements of the *Family and Domestic Violence Practice Guidance*, in particular, that '[w]here a VRO is considered desirable or necessary but a decision is made for the Department not to apply for the order, the non-abusive adult victim should be given an active referral for legal advice and help from an appropriate service'.

Further, the report noted DCPFS's *Family and Domestic Violence Practice Guidance* also identifies that taking out a violence restraining order on behalf of a child 'can assist in the protection of that child without the need for removal (intervention action) from his or her family home', and can serve to assist adult victims of violence when it would decrease risk to the adult victim if the Department was the applicant. In the report, the Ombudsman made three recommendations relating to DCPFS's improved compliance with the provisions of its *Family and Domestic Violence Practice Guidance* in seeking violence restraining orders on behalf of children (Recommendations 45, 46 and 47), including:

> Recommendation 45: In its implementation of section 18(2) of the *Restraining Orders Act 1997*, DCPFS complies with its *Family and Domestic Violence Practice Guidance* which identifies that DCPFS officers should consider seeking a violence restraining order on behalf of a child if the violence is likely to escalate and the children are at risk of further abuse, and/or it would decrease risk to the adult victim if the Department was the applicant for the violence restraining order.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that in relation to Recommendations 44, 45, 46 and 47, DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. The State Strategy identifies the need to '[s]upport the long-term recovery and wellbeing of children who have experienced family and domestic violence' as a Priority Action. Communities' *Casework Practice Manual 2.3.3 Family violence restraining orders* provides practice guidance for 'child protection workers about applying for a Family Violence Restraining Order (FVRO) on behalf of a child or supporting adult victims to seek FVROs that include themselves and their children'. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Support during the process of obtaining a family violence restraining order

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified the importance of opportunities for victims to seek help and for perpetrators to be held to account throughout the process for obtaining a, then, violence restraining order, and

that these opportunities are acted upon, not just by WA Police Force but by all State Government departments and authorities. In the report the Ombudsman recommended that:

> Recommendation 14: In developing and implementing future phases of *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, DCPFS specifically identifies and incorporates opportunities for state government departments and authorities to deliver information and advice about violence restraining orders, beyond the initial response by WAPOL.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps to give effect to this recommendation.

Subsequent to this recommendation, in May 2020, initiated in the context of concerns for increased family and domestic violence during COVID-19 restrictions, new laws were introduced to enable victims of family and domestic violence to apply for family violence restraining orders online through registered legal services which provide family violence assistance. Today, this action is intended to make it more convenient and less stressful for victims to obtain family violence restraining orders.

The State Strategy identifies that victims of family and domestic violence 'often need information, social support and legal advice on a range of issues such as…restraining orders. Actions under the Strategy will focus on making this available at an early stage to support people's safety and wellbeing and help them make informed choices'. Action Item 17 of the First Action Plan intends to '[e]xplore options to improve early access to legal advice for victims and perpetrators of family and domestic violence'. The outcome of Action Item 17 will be considered by this office in future family and domestic violence reviews.

Support when a family violence restraining order has not been granted

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined a sample of 41,229 hearings regarding violence restraining orders and identified that an application for a, then, violence restraining order was dismissed or not granted as an outcome of 6,988 hearings (17%) in the investigation period. In cases where an application for a violence restraining order has been dismissed it may still be appropriate to provide safety planning assistance. In the report, the Ombudsman recommended that:

> Recommendation 25: DOTAG, in collaboration with DCPFS, identifies and incorporates into *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*, ways of ensuring that, in cases where an application for a violence restraining order has been dismissed, if appropriate, victims are provided with referrals to appropriate safety planning assistance.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DOTAG and DCPFS had proposed steps to be taken to give effect to this recommendation.

Provision of support to victims experiencing family and domestic violence

In November 2015, DCPFS launched the *Western Australia Family and Domestic Violence Common Risk Assessment and Risk Management Framework (Second edition)* (available at WA.gov.au). This across-government framework states that:

> The purpose of risk assessment is to determine the risk and safety for the adult victim and children, taking into consideration the range of victim and perpetrator risk factors that affect the likelihood and severity of future violence.
>
> Risk assessment must be undertaken when family and domestic violence has been identified…
>
> Risk assessment is conducted for a number of reasons including:
>
> - evaluating the risk of re-assault for a victim;
> - evaluating the risk of homicide;
> - informing service system and justice responses;
> - supporting women to understand their own level of risk and the risk to children and/or to validate a woman's own assessment of her level of safety; and
> - establishing a basis from which a case can be monitored.
>
> (pages 36-37)

The Ombudsman's family and domestic violence fatality reviews and the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, have noted that, where agencies become aware of family and domestic violence, they do not always undertake a comprehensive assessment of the associated risk of harm and provide support and safety planning.

In the report, the Ombudsman made eight recommendations (Recommendations 40 – 44 and 48 – 50) to public authorities that they ensure compliance with their family and domestic violence policy requirements, including assessing risk of future harm and providing support to address the impact of experiencing family and domestic violence.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to all these recommendations. Subsequent to these recommendations, Action Item 12 of the First Action Plan intends to update the *Common Risk Assessment and Risk Management Framework* to '[s]trengthen approaches to risk management and information sharing'. The Office will continue to monitor, and report on, the steps being taken to implement these recommendations.

Agency interventions to address perpetrator behaviours

Based on the information available to the Office, in 48 (58%) of the 83 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2023, prior family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities. The Ombudsman's reviews identify where perpetrators have a history of reported violence, with one or more partners, and examines steps taken to hold perpetrators to account for their actions and support them to cease their violent behaviours.

The Ombudsman's reviews have noted that victims and perpetrators of family and domestic violence may be under the age of 18 years. Youth intimate partner violence may require a different response to adult intimate partner violence, particularly to address perpetrator behaviours.

Case Study

Responding to youth intimate partner violence

In reviewing a family and domestic violence fatality involving youth intimate partner violence, the Ombudsman has identified the need for WA Police Force to amend practice, so that such matters are not closed without proceeding to a Family Violence Incident Report and referral to the Family and Domestic Violence Response Team, to enable the provision of support to the youth perpetrator and/or youth victim. The Ombudsman made the following recommendation:

> That the WA Police Force provides this office with the amended version of its *Family Violence Procedural Guidelines* once finalised, confirming that all FDV incidents involving children will require submission of a *Family Violence Incident Report* and cannot be closed at computer aided dispatch.

Fatalities with no prior reported family and domestic violence

Based on the information available to the Office, in 35 (42%) of the 83 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2023, the fatal incident was the only family and domestic violence between the parties that had been reported to WA Police Force and/or other public authorities. It is important to note, however, research indicating under-reporting of family and domestic violence. The Australian Bureau of Statistics' *Personal Safety Survey 2016* (www.abs.gov.au) collected information about help seeking behaviours, noting that:

- In the most recent incident of physical assault by a male, women were most likely to be physically assaulted by a male that they knew (92% or 977,600).

And

- Two-thirds of men and women who experienced physical assault by a male did not report the most recent incident to police (69% or 908,100 for men and 69% or 734,500 for women).

The Ombudsman's reviews provide information on family and domestic violence fatalities where there is no previous reported history of family and domestic violence, including cases where information becomes available after the death to confirm a history of unreported family and domestic violence, drug or alcohol use, or mental health issues that may be relevant to the circumstances of the fatality.

The Ombudsman will continue to collate information on family and domestic violence fatalities where there is no reported history of family and domestic violence, to identify patterns and trends and consider improvements that may increase reporting of family and domestic violence and access to supports.

Family violence involving Aboriginal people

Of the 160 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2023, Aboriginal Western Australians were over-represented, with 53 (33%) persons who died being Aboriginal. In all but six cases, the suspected perpetrator was also Aboriginal. There were 41 of these 53 fatalities where the person who died lived in a regional or remote area of Western Australia, of which 31 were intimate partner fatalities.

The Ombudsman's family and domestic violence fatality reviews and the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* November 2015, identify the over-representation of Aboriginal people in family and domestic violence fatalities. This is consistent with the research literature that Aboriginal people are 'more likely to be victims of violence than any other section of Australian society' (Cripps, K and Davis, M, *Communities working to reduce Indigenous family violence*, Brief 12, Indigenous Justice Clearinghouse, New South Wales, June 2012, p. 1) and that Aboriginal people experience family and domestic violence at 'significantly higher rates than other Australians' (Aboriginal and Torres Strait Islander Social Justice Commissioner, *Ending family violence and abuse in Aboriginal and Torres Strait Islander communities – Key Issues, An overview paper of research and findings by the Human Rights and Equal Opportunity Commission, 2001 – 2006*, Human Rights and Equal Opportunity Commission, June 2006, p. 6).

Contextual factors for family violence involving Aboriginal people

As discussed in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities,* November 2015, the research literature suggests that there are a number of contextual factors contributing to the prevalence and seriousness of family violence in Aboriginal communities and that:

> …violence against women within the Indigenous Australian communities need[s] to be understood within the specific historical and cultural context of colonisation and systemic disadvantage. Any discussion of violence in contemporary Indigenous communities must be located within this historical context. Similarly, any discussion of "causes" of violence within the community must recognise and reflect the impact of colonialism and the indelible impact of violence perpetrated by white colonialists against Indigenous peoples
>
> … A meta-evaluation of literature … identified many "causes" of family violence in Indigenous Australian communities, including historical factors such as: collective dispossession; the loss of land and traditional culture; the fragmentation of kinship systems and Aboriginal law; poverty and unemployment; structural racism; drug and alcohol misuse; institutionalisation; and the decline of traditional Aboriginal men's role and status – while "powerless" in relation to mainstream society, Indigenous men may seek compensation by exerting power over women and children...
>
> (Blagg, H, Bluett-Boyd, N, and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 3).

The report notes that, in addition to the challenges faced by all victims in reporting family and domestic violence, the research literature identifies additional disincentives to reporting family and domestic violence faced by Aboriginal people:

> Indigenous women continuously balance off the desire to stop the violence by reporting to the police with the potential consequences for themselves and other family members that may result from approaching the police; often concluding that the negatives outweigh the positives. Synthesizing the literature on the topic reveals a number of consistent themes, including: a reluctance to report because of fear of the police, the perpetrator and perpetrator's kin; fear of "payback" by the offender's family if he is jailed; concerns the offender might become "a death in custody"; a cultural reluctance to become involved with non-Indigenous justice systems, particularly a system viewed as an instrument of dispossession by many people in the Indigenous community; a degree of normalisation of violence in some families and a degree of fatalism about change; the impact of "lateral violence" … which makes victims subject to intimidation and community denunciation for reporting offenders, in Indigenous communities; negative experiences of contact with the police when previously attempting to report violence (such as being arrested on outstanding warrants); fears that their children will be removed if they are seen as being part of an abusive house-hold; lack of transport on rural and remote communities; and a general lack of culturally secure services.
>
> (Blagg, H, Bluett-Boyd, N and Williams, E, *Innovative models in addressing violence against Indigenous women: State of knowledge paper*, Australia's National Research Organisation for Women's Safety Limited, Sydney, New South Wales, August 2015, p. 13).

More recently, the ANROWS (Australian National Research Organisation for Women's Safety) Horizons Research Report entitled *Innovative Models in addressing violence against Indigenous women: Final report* (January 2018, available at www.anrows.org.au) informs:

> This research report undertakes a critical inquiry into responses to family violence in a number of remote communities from the perspective of Aboriginal people who either work within the family violence space or have had experience of family violence. It explicitly foregrounds Indigenous knowledge of family violence, arguing that Indigenous knowledge departs from what we call in this report "mainstream knowledge" in a number of critical respects. The report is based on qualitative research in three sites in Australia: Fitzroy Crossing (Western Australia), Darwin (Northern Territory), and Cherbourg (Queensland). It supports the creation of a network of regionally based Indigenous family violence strategies owned and managed by Indigenous people and linked to initiatives around alcohol reduction, intergenerational trauma, social and emotional wellbeing, and alternatives to custody. The key theme running through our consultations was that innovative practice must be embedded in Aboriginal law and culture. This recommendation runs counter to accepted wisdom regarding intervention in family and domestic violence, which tends to assume that gender trumps other differences, and that violence against women results from similar forms of oppression, linked to gender inequalities and patriarchal forms of power. While not disputing the role of gender and coercion in underpinning much violence against Indigenous women, we, nonetheless, claim that a distinctively Indigenous approach to family violence necessitates exploring causal factors that reflect specifically Indigenous experiences of colonisation and its aftermath. (page 9)

The Ombudsman's reviews and report have Identified that Aboriginal victims want the violence to end, but not necessarily always through the use of family violence restraining orders. The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman has made four recommendations that seek to support community led solutions. The implementation of these recommendations is reported later in this section.

A separate strategy to prevent and reduce Aboriginal family violence

In examining the family and domestic violence fatalities involving Aboriginal people, the research literature and stakeholder perspectives, the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified a gap in that there is no strategy solely aimed at addressing family violence experienced by Aboriginal people and in Aboriginal communities.

The findings of the report strongly support the development of a separate strategy that is specifically tailored to preventing and reducing Aboriginal family violence. This can be summarised as three key points.

Firstly, the findings set out in Chapters 4 and 5 of the report identify that Aboriginal people are over-represented, both as victims of family and domestic violence and victims of fatalities arising from this violence.

Secondly, the research literature, discussed in Chapter 6 of the report suggests a distinctive '…nature, history and context of family violence in Aboriginal and Torres Strait Islander communities' (National Aboriginal and Torres Strait Islander Women's Alliance, *Submission to the Finance and Public Administration Committee Inquiry into Domestic Violence in Australia*, National Aboriginal and Torres Strait Islander Women's Alliance, New South Wales, 31 July 2014, p. 5). The research literature further suggests that combating violence is likely to require approaches that are informed by and respond to this experience of family violence.

Thirdly, the findings set out in the report demonstrate how the unique factors associated with Aboriginal family violence have resulted in important aspects of the use of violence restraining orders by Aboriginal people which are different from those of non-Aboriginal people.

The report also identified that development of the strategy must include and encourage the involvement of Aboriginal people in a full and active way, at each stage and level of the development of the strategy, and be comprehensively informed by Aboriginal culture. Doing so would mean that an Aboriginal family violence strategy would be developed with, and by, Aboriginal people. In the report, the Ombudsman recommended that:

> Recommendation 4: DCPFS, as the lead agency responsible for family and domestic violence strategic planning in Western Australia, develops a strategy that is specifically tailored to preventing and reducing Aboriginal family violence, and is linked to, consistent with, and supported by *Western Australia's Family and Domestic Violence Prevention Strategy to 2022: Creating Safer Communities*.
>
> Recommendation 6: In developing a strategy tailored to preventing and reducing Aboriginal family violence, referred to at Recommendation 4, DCPFS actively invites and encourages the involvement of Aboriginal people in a full and active way at each stage and level of the process, and be comprehensively informed by Aboriginal culture.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to these recommendations. In December 2022, seven years after the Ombudsman recommendation, Communities launched the *Aboriginal Family Safety Strategy 2022-2032*. This Office will continue to monitor the finalisation and implementation of the *Aboriginal Family Safety Strategy 2022-2032*.

Case Study

Ensuring culturally safe and responsive practice

In reviewing a youth intimate partner fatality, where the families were known to Communities, the Ombudsman has identified the importance of culturally safe and responsive practice. The Ombudsman made the following recommendation:

> That the Department of Communities undertakes immediate and ongoing action to provide culturally safe and responsive practice in the context of Child Safety Investigatio''s and Intensive Family Support, and associated statutory obligations, with Aboriginal children and families, across the State, while the long-term work of the *Aboriginal Cultural Capability Reform Program* is progressed. Communities will provide a report to the Ombudsman, within three months of the finalisation of this review, on the progress of the immediate and ongoing actions that are being implemented.

Limited use of violence restraining orders

The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, identified that while Aboriginal people are significantly over-represented as victims of family and domestic violence, they are less likely than non-Aboriginal people to seek a violence restraining order. The report examined the research literature and views of stakeholders on the possible reasons for this lower use of violence restraining orders by Aboriginal people, identifying that the process for obtaining a violence restraining order is not necessarily always culturally appropriate for Aboriginal victims and that Aboriginal people in regional and remote locations face additional logistical and structural barriers in the process of obtaining a violence restraining order.

In the report, the Ombudsman recommended that:

> Recommendation 23: DOTAG, in collaboration with key stakeholders, considers opportunities to address the cultural, logistical and structural barriers to Aboriginal victims seeking a violence restraining order, and ensures that Aboriginal people are involved in a full and active way at each stage and level of this process, and that this process is comprehensively informed by Aboriginal culture.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DOTAG had taken steps and proposed steps to be taken to give effect to this recommendation. Subsequent to this recommendation, Action Item 25 of the First Action Plan intends to '[d]evelop a Department of Justice Aboriginal Family Safety Strategy'. More recently, in December 2022, the Department of Justice informed this office that work has commenced to develop this *Aboriginal Family Safety Strategy*. The Office will continue to monitor, and report on, the steps being taken to implement this action item.

The November 2015 report noted that data examined by the Office concerning the use of police orders and violence restraining orders by Aboriginal people in Western Australia indicates that Aboriginal victims are more likely to be protected by a police order than a violence restraining order. This data is consistent with information examined in the Ombudsman's reviews of family and domestic violence fatalities involving Aboriginal people. In the report, the Ombudsman recommended that:

> Recommendation 16: DCPFS considers the findings of the Ombudsman's investigation regarding the link between the use of police orders and violence restraining orders by Aboriginal people in developing and implementing the Aboriginal family violence strategy referred to in Recommendation 4.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to this recommendation.

The findings from the Ombudsman's family and domestic violence fatality reviews and the own motion investigations will contribute to the development of Action Item 25 of the First Action Plan, and the Office will continue to monitor, and report on, the steps being taken to implement Recommendation 16 from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015.

Strategies to recognise and address the co-occurrence of alcohol consumption and Aboriginal family violence

The Ombudsman's reviews of the family and domestic violence fatalities of Aboriginal people and prior reported family violence between the parties, identify a high co-occurrence of alcohol consumption and family violence. The *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015, examined the research literature on the relationship between alcohol use and family and domestic violence and found that the research literature regularly identifies alcohol as 'a significant risk factor' associated with intimate partner and family violence in Aboriginal communities (Mitchell, L, *Domestic violence in Australia – an overview of the issues*, Parliament of Australia, 2011, Canberra, accessed 16 October 2014, pp. 6-7). As with family and domestic violence in non-Aboriginal communities, the research literature suggests that 'while alcohol consumption [is] a common contributing factor … it should be viewed as an important situational factor that exacerbates the seriousness of conflict, rather than a cause of violence' (Buzawa, E, Buzawa, C and Stark, E, *Responding to Domestic Violence*, Sage Publications, 4th Edition, 2012, Los Angeles, p. 99; Morgan, A. and McAtamney, A. 'Key issues in alcohol-related violence,' *Australian Institute of Criminology*, Canberra, 2009, viewed 27 March 2015, p. 3).

In the report, the Ombudsman recommended that:

> Recommendation 5: DCPFS, in developing the Aboriginal family violence strategy referred to at Recommendation 4, incorporates strategies that recognise and address the co-occurrence of alcohol use and Aboriginal family violence.

A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to this recommendation. The *Aboriginal*

Family Safety Strategy 2022-2032, launched by Communities in December 2022, identifies 'the need to respond to the different drivers of violence experienced by Aboriginal people, which may include poor or inadequate housing, barriers to accessing services, high rates of imprisonment, unemployment and alcohol and other substance use'. It is anticipated that further information on addressing these drivers will be available when an associated action plan is released.

Strategies to address the over-representation of family violence involving Aboriginal people in regional WA

Of the 53 family and domestic violence fatality reviews finalised from 1 July 2012 to 30 June 2023 involving Aboriginal people, 41 (77%) of the Aboriginal people who died lived in a regional or remote area of Western Australia. Nineteen (36%) of the Aboriginal people who died lived in the Kimberley region, which is home to 1.3% of all people and 16% of Aboriginal people in the Western Australian population.

As outlined above, *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2016, identified that DCPFS had taken steps and proposed steps to be taken to give effect to Recommendations 4 and 6 of the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015. These recommendations related to DCPFS developing 'a strategy that is specifically tailored to preventing and reducing Aboriginal family violence' that would encompass all regions of Western Australia and would ensure actively inviting and encouraging 'the involvement of Aboriginal people in a full and active way at each stage and level of the process' and being 'comprehensively informed by Aboriginal culture'. Subsequent to these recommendations, Item 5 of the First Action Plan intends to '[c]o-design the Aboriginal Family Safety Strategy with Aboriginal people and communities'. The *Aboriginal Family Safety Strategy 2022-2032* was launched by Communities in December 2022 and associated action plans are yet to be released, The Ombudsman's reviews have also examined agency action to facilitate co-design of locally based solutions to promote Aboriginal family and community safety. In 2020-21, the Ombudsman made four recommendations that seek to support community led solutions. The implementation of these recommendations is reported later in this section.

Factors co-occurring with family and domestic violence

Where family and domestic violence co-occurs with alcohol use, drug use and/or mental health issues, a collaborative, across service approach is needed. Treatment services may not always identify the risk of family and domestic violence and provide an appropriate response.

Co-occurrence with alcohol and other drug use

Consistent with the research literature relating to the co-occurrence between alcohol consumption and/or drug use and incidents of family and domestic violence (as outlined in the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, November 2015), the State Strategy notes that:

> Other intersecting factors, such as mental ill health and problematic use of alcohol and other drugs, can compound the severity and consequences of family and domestic violence. Mental ill health and the use of alcohol and other drugs do not cause family and domestic violence, but their contribution to the frequency and severity of violence and abuse means consideration of these factors is critical in the responses developed under this Strategy.

On the information available, relating to the 129 family and domestic violence fatalities involving alleged homicide that were finalised from 1 July 2012 to 30 June 2023, the Office's reviews identify where alcohol use and/or drug use are factors associated with the fatality, and where there may be a history of alcohol use and/or drug use.

	ALCOHOL USE		DRUG USE	
	Associated with fatal event	Prior history	Associated with fatal event	Prior history
Person who died only	4	6	6	10
Suspected perpetrator only	11	18	19	24
Both person who died and suspected perpetrator	40	48	15	26
Total	**55**	**72**	**40**	**60**

Stakeholders have suggested to the Ombudsman that programs and services for victims and perpetrators of violence in Western Australia, including family and domestic violence, do not address its co-occurrence with alcohol and other drug abuse. Specifically, this means that programs and services addressing family and domestic violence:

- May deny victims or perpetrators access to their services, particularly if they are under the influence of alcohol and other drugs; and
- Frequently do not address victims' or perpetrators' alcohol and other drug abuse issues.

Conversely, stakeholders have suggested programs and services which focus on alcohol and other drug use generally do not necessarily:

- Address perpetrators' violent behaviour; or
- Respond to the needs of victims resulting from their experience of family and domestic violence.

The Office will monitor the effectiveness of the State Strategy to reduce family and domestic violence, in responding to family and domestic violence and co-occurrence with alcohol and drugs.

Co-occurrence of mental health issues

As noted in the previous section, the State Strategy recognises that 'mental ill health…can compound the severity and consequences of family and domestic violence'.

The Ombudsman's reviews have examined steps taken by mental health service providers to assess patient risk of violence and to develop relevant safety planning where appropriate. The Office will continue to monitor action taken by mental health service providers to reduce the risk of family and domestic violence fatalities.

Issues Identified in Family and Domestic Violence Fatality Reviews

The following are the types of issues identified when undertaking family and domestic violence fatality reviews.

It is important to note that:

- Issues are not identified in every family and domestic violence fatality review; and
- When an issue has been identified, it does not necessarily mean that the issue is related to the death.

- Not providing culturally safe and responsive practice when working with Aboriginal families.
- Not using interpreters where appropriate.
- Not complying with agency policy and practices in responding to family and domestic violence, and limited effective governance to ensure compliance.
- Missed opportunities to address family and domestic violence perpetrator accountability.
- Missed opportunities for body worn camera activation while investigating reported incidents of FDV.
- Not adequately investigating offences in the context of family and domestic violence.
- Missed opportunities to address family and domestic violence victim safety.
- Missed opportunity to respond to youth intimate partner family and domestic violence.
- Missed opportunity to assess risk of harm and develop strategies to reduce or prevent family and domestic violence in the context of mental health issues and/or drug and alcohol use.
- Not undertaking sufficient family, intra-agency, inter-agency and Aboriginal Community Controlled Organisation communication to enable effective case management and collaborative responses.
- Not adequately meeting policy and procedures of the Family and Domestic Violence Response Team, including instigation of multi-agency case management meetings.
- Inaccurate recordkeeping.

Recommendations

In response to the issues identified, the Ombudsman makes recommendations to prevent or reduce family and domestic violence fatalities. The following six recommendations were made by the Ombudsman in 2022-23 arising from family and domestic violence fatality reviews (certain recommendations may be de-identified to ensure confidentiality).

1. That the WA Police Force provides this office with the amended version of its *Family Violence Procedural Guidelines* once finalised, confirming that all family and domestic violence incidents involving children will require submission of a *Family Violence Incident Report* and cannot be closed at computer aided dispatch.

2. The WA Police Force accept that family and domestic violence and Aboriginal Family Violence is a crime of violence predominantly perpetrated by men (including young men) against predominantly women (including young women), that no culture accepts this violence and that it is condemned by all cultures, and that the role of the WA Police Force, as first responders, is always to protect primary and secondary victims (i.e. children of primary victims) from violence, using every legal means possible. WA Police Force will continue to ensure that its recruitment, training and standards monitoring reflect this fact.

3. That Communities undertakes an audit of the provision of case practice guidance, including supervision and consultation to the Regional Child Safety Team and Regional Intensive Family Support team, with the outcome of this audit, and all relevant documentation, to be provided to the Ombudsman within six months of the completion of this family and domestic violence fatality review.

   The audit should:
   a. Identify any barriers and contextual factors to the provision of case practice guidance, including supervision and consultation in the Regional District in accordance with Communities' standards and practice requirements in all the circumstances; and
   b. Evaluate the quality and quantity of case practice guidance, including supervision and consultation delivered in the Regional District from 1 January 2022 to 30 June 2022.

4. That Communities undertakes immediate and ongoing action to provide culturally safe and responsive practice in the context of Child Safety Investigation's and Intensive Family Support, and associated statutory obligations, with Aboriginal children and families, across the State, while the long-term work of the Aboriginal Cultural Capability Reform Program is progressed. Communities will provide a report to the Ombudsman, within three months of the finalisation of this review, on the progress of the immediate and ongoing actions that are being implemented.

5. WA Country Health Service provides this office with an update, within six months of the finalisation of this review, on the progress of the 'audit' referred to in the WACHS Cultural Governance Framework, relating to current tools used to assess Aboriginal patient's 'physical, spiritual, social and emotional wellbeing', with respect to alleged FDV, mental health issues, adolescent substance use and child protection risk, across hospital and community health services, to confirm

these tools are culturally valid, and that associated pathways for risk identified by these tools are culturally responsive and effective.

6. That the Department of Education reports back to the Ombudsman, six months following finalisation of this review, outlining its consideration of whether further action is required to:
   a. provide support to school aged children who are pregnant and/or parenting; and
   b. promote school aged pregnant and/or parenting students' engagement in education, in accordance with Part 2, Divisions 1 and 3 of the School Education Act 1999.

   This consideration includes, but is not limited to:
   (i) minimum standards of practice.
   (ii) current guidance to schools and regions (including Participation Teams).
   (iii) culturally informed responsive practice for Aboriginal and Torres Strait Islander students, and Culturally and Linguistically Diverse students.

   to optimise education achievement and outcomes.

The Ombudsman's *Annual Report 2023-24* will report on the steps taken to give effect to the one recommendation made about ways to prevent or reduce family and domestic violence fatalities in 2021-22. The Ombudsman's *Annual Report 2024-25* will report on the steps taken to give effect to the six recommendations made about ways to prevent or reduce family and domestic violence fatalities in 2022-23.

Steps taken to give effect to the recommendations arising from family and domestic violence fatality reviews in 2020-21

The Ombudsman made eight recommendations about ways to prevent or reduce family and domestic violence fatalities in 2020-21. The Office has requested that the relevant public authorities notify the Ombudsman regarding:

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations; or
- If no such steps have been, or are proposed to be taken, the reasons therefor.

Recommendation 1: In the context of Communities' commitment to the development of Aboriginal led, co-designed, local solutions to reduce family and domestic violence and promote safety, Communities provides a report to the Ombudsman by 31 December 2020 on the progress of the engagement with the Remote community to develop strategies to promote safety for women, children, and families.

Steps taken to give effect to the recommendation

Communities provided this office with a letter dated 5 January 2021, in which Communities relevantly informed this Office that:

In recognition of the number of family violence fatalities and child deaths that have occurred in similar circumstances in the Region, Communities has been working with stakeholders to identify and address the recurrent issues…

This progress update includes an overview of the work underway...

Focus one: Safety of Aboriginal women and children in Remote community

…Communities has been working to engage and build relationships with the Remote community to facilitate discussion about family violence, and options or opportunities to improve responses and create safety. The engagement work is primarily being facilitated through three processes:

1. establishment of the Joint Response Team;
2. engagement via the Regional Coordinator and Aboriginal Practice Leader; and
3. building relationships with the Community Chairperson and Remote community Aboriginal Corporation Board.

…Communities and WA Police Force have established a Joint Response Team (JRT) in the Region…Deployment of the JRT has provided the ideal opportunity to support and facilitate discussions about community safety overall, including in relation to family violence.

The JRT visits the Remote community and communities in the Region on a fortnightly basis (each location monthly)…The JRT is working to build relationships with the community to enable discussions and planning about the safety of women and children.

…

The JRT is also routinely accompanied by the district Aboriginal Practice Leader who assists with supporting culturally informed and appropriate engagement including in relation to following cultural protocols, understanding community governance and leadership, and connecting with key community members.

…

Thus far, the regular community engagement with the Remote community via the JRT, has enabled discussion about a range of safety measures that the community wishes to implement. These measures are wide ranging and include:

- how services (including WA Police Force) interact with, and respond to episodes of family violence;
- provisions for improving community safety at night, including improved lighting and installation of CCTV cameras;
- establishing a safe house; and
- introducing controls on young people's internet access to limit access to pornography (considered by the community to be a factor contributing to sexualised behaviours).

…

Focus three: Responding to family violence

Common themes arising from the Ombudsman's review of child deaths and family violence fatalities has been:

- the suitability of mainstream interventions for addressing Aboriginal family violence, particularly for women and children in remote locations;

- lack of understanding about family violence among professionals including the dynamics of coercive control and related indicators of risk for women and children. In several cases this was demonstrated to lead to incident focused assessment of family violence and plans for safety that did not adequately address the documented risk;
- lack of information exchange, coordination or collaboration between services to reduce or manage risk; and
- gaps in service system responses to women without children who are experiencing family violence, particularly following a WA Police Force response to family violence;

Communities is leading and/or involved in a range of initiatives to address these issues and improve responses to family violence. In the Region this includes development of a regional plan for responding to family violence. The regional plan will be aligned to *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020-2030* and will set out the work across government and community sector services that will be a focus in the Region. It will be developed and managed via a working group of the District Leadership Group.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned

Further information on Communities' engagement with the Remote community to develop strategies to promote safety for women, children, and families is outlined in Recommendation 8 below.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 2: DOJ provides a report to the Ombudsman by 31 March 2021 on:

- **the progress of discussions with the Western Australia Police Force to promote DOJ's timely access to Family Violence Incident Reports when managing family and domestic violence offenders on Community Based Orders; and**
- **the outcomes of the process evaluation of the Domestic Violence Screening Instrument (DVSI - R) for use with family and domestic violence offenders on Community Based Orders.**

Steps taken to give effect to the recommendation

DOJ provided this office with a letter dated 15 March 2021, in which DOJ relevantly informed this Office that:

The Department of Justice (the Department) is currently collating information at the request of the WA Police Force Information Management Directorate to support an application for Department staff to access FVIR's direct from the Police Incident Management System (IMS). Once approved, select Departmental staff will have access

to WA Police Force information that will be used to inform the assessment of adult FDV offenders serving an effective sentence of six months or greater in custody, and those managed in the community on Community Based Orders. The application for the Department to access IMS is part of an in-principle agreement between both agencies to develop a two-way information exchange process specifically relating to FDV perpetrators.

The DVSI-R pilot evaluation was finalised in November 2020 and the overall findings and feedback from Adult Community Corrections (ACC) staff was positive. It was reported that the tool was easy to use and fostered a more holistic approach to the assessment and case management of FDV offenders across agencies. It was noted that the use of a more diverse collection of information sources, including access to FVIR's provided a comprehensive profile of the offender's pattern of FDV behaviours and provided a greater victim focus.

The evaluation recommended that the roll out of the DVSI-R is extended to provide a more representative sample of community based offenders to further assess the discriminative and predictive ability of the tool. In response to this, ACC officers in the regions have been trained in the use of DVSI-R and are currently cascading the training across their respective areas.

This Office requested that DOJ inform the Office of any further information on the steps taken to give effect to the recommendation. In response, DOJ provided a range of information in a letter to this Office dated 15 March 2023, containing a report prepared by DOJ.

In DOJ's report, DOJ relevantly informed this Office that:

The Department has taken steps to give effect to the recommendation.

…in July 2022, a meeting was held between the Department, WA Police Force and the Department of Communities to discuss improvements to information sharing between these agencies.

An agreement was reached to establish a multi-agency Information Sharing Project comprising of three streams: Business, Legal and Technical Advisory Groups.

The objectives of these groups are to identify:

- opportunities to improve information sharing;
- what information would be beneficial; and
- technical or legal barriers that may hinder information exchange and whether information exchange should be limited to any person of interest or only relate to family violence.

To progress work by the Advisory Groups, a detailed list has been provided of the types of WA Police Force information that if shared with the Department could improve the case management of FDV offenders subject to Court and Early Release Orders.

…

Further to the Department's March 2021 report regarding the second element of the Ombudsman recommendation: State-wide rollout of the DVSI-R was completed in late

2021 for use by the Department's ACC. The DVSI-R screening tool is fully implemented as business as usual for ACC. When combined with other risk assessment tools, the DVSI-R enhances the assessment of FDV perpetrators including the risk of harm they pose to the victim/others and guides case management practice.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 3: Communities considers if any action is required to ensure safety planning for the parents' wellbeing is undertaken to address the potential escalation of FDV risk when a child is taken into the Chief Executive Officer's care in the context of FDV, in accordance with Section 2.3.5 Safety planning for emotional abuse - FDV of the Department's Casework Practice Manual, and reports back to the Ombudsman on the outcome of this consideration by 30 April 2021.

Steps taken to give effect to the recommendation

Communities provided this office with a letter dated 11 May 2021, in which Communities relevantly informed this Office that:

> Communities acknowledges that where a child is taken into the Chief Executive Officer (CEO's) care in the context of FDV, there is the potential for an escalation of risk to the adult survivor. Communities aims to reduce this risk via operational child protection responses and systemic mechanisms such as the Family and Domestic Violence Response Teams (FDVRT).
>
> Currently, Communities is consolidating FDV operations to ensure FDV informed approaches are embedded across child protection responses. This includes initiatives to strengthen responses to families who are experiencing FDV, including parents and adult survivors who have had children brought into the CEO's care, such as:
>
> - work towards the development of an FDV Informed Approach;
> - the review of Communities practice guidance in relation to FDV with a focus on child protection guidance, in accordance with the further development of the FDV Informed Approach;
> - the review of the FDVRTs; and
> - Safety Planning Bootcamps being delivered in Districts in 2021, which have a focus on safety planning responses to FDV.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> Current Status
>
> *Signs of Safety Bootcamps*
>
> In 2021, three day Signs of Safety Bootcamps were delivered in each child protection District. The Bootcamps had a focus on safety planning where concerns include FDV.

FDV Practice Guidance

The *Emotional Abuse – FDV Assessment Toolkit* (the Toolkit), which is available on the CPM as a Related Resource, contains guidance outlining that service intervention, including WA Police Force or child protection, can result in an escalation in a perpetrator's use of violence. Further, the Toolkit contains guidance for personal safety planning, including questioning prompts to explore increased times of danger.

Office of Prevention of Family and Domestic Violence

In March 2022, a dedicated Office for Prevention of Family and Domestic Violence (OPFDV) was established in the Strategy and Partnerships division of Communities. The intent of the OPFDV is to enhance the coordination, development, and implementation of family and domestic violence strategic policy across Western Australia, with a focus on improved outcomes in primary prevention, Aboriginal family safety, victim-survivor safety and perpetrator accountability…

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 4: Communities, with input from Regional Aboriginal communities including Aboriginal Community Controlled Organisations, reviews the five Tjallara Consulting documents on the Law and Culture Community Engagement Framework to consider their value for engagement with Aboriginal communities in the Regional district to co-design strategies to promote Aboriginal family and community safety and, informs the Ombudsman on the outcome by 30 September 2021.

Steps taken to give effect to the recommendation

Communities provided this office with a letter dated 29 September 2021, in which Communities relevantly informed this Office that:

> In line with the Ombudsman of Western Australia's recommendation, Communities has reviewed and considered the value of the five Tjallara Consulting documents on the *Law and Culture Community Engagement Framework* for engagement with Aboriginal communities in the Kimberley and more broadly across Western Australia. As you might be aware in July 2021, Communities contracted Tjallara Consulting (Managing Director, Professor Victoria Hovane) to engage with key stakeholders across the State including government, Aboriginal Community Controlled Organisations (ACCOs) and the sector to consult and co-design the development of the Aboriginal Family Safety Strategy. There were obvious synergies and efficiencies to be gained from the same consultant undertaking this important work. Communities will have ongoing discussions with Tjallara Consulting around the applicability and the appropriateness of the five documents on Law and Culture Community Engagement Framework that they developed when engaging ACCOs. Tjallara Consulting is currently completing these consultations. Communities will continue to keep the Ombudsman informed of the development of the Strategy and the resources used to inform this work.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In the Communities' report, Communities relevantly informed this Office that:

This recommendation has been actioned.

Since this update, the Aboriginal Family Safety Strategy was finalised and released, informed by consultation with more than 1000 people.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 5: That, for the period 2020-2022 prior to the co-design of the Aboriginal Family Safety Strategy, in its development of an FDV-Informed Approach underpinned by Safe & Together principles and core components, Communities:

- **requests the Aboriginal Cultural Council, in accordance with its remit of 'offering advice from an Aboriginal perspective, ensuring policy and practice development is informed with a cultural viewpoint', provide Communities with advice about the cultural safety of the Safe & Together Model for use across the diverse population of Aboriginal people, families and communities in Western Australia, including whether further action is required to 'validate' of 'adapt' the model to ensure cultural safety; and**
- **provides this Office with a report on the advice provided by the Aboriginal Cultural Council and, if relevant, information about how Communities will address that advice.**

Steps taken to give effect to the recommendation

Following the provision of this recommendation, the Communities Aboriginal Cultural Council was discontinued. This Office met with Communities on 30 June 2021 to discuss progression of this recommendation, in the absence of the Communities' Aboriginal Cultural Council structure. Communities subsequently provided this Office with an email dated 18 August 2021, in which Communities relevantly informed this Office that consultation had occurred with Yorgum Healing Services, Wungening Aboriginal Corporation and Men's Outreach Service Aboriginal Corporation (MOSAC) in relation to the recommendation. Communities then provided this Office with a letter dated 31 August 2021, in which Communities provided a copy of the report prepared by Communities: *Further consultation with Aboriginal people on the Safe and Together principles and critical components*. The report states that:

> …all three organisations stated they find the Safe and Together principles and critical components a suitable approach for their work with Aboriginal families experiencing family and domestic violence.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> In implementing the Ombudsman's recommendation, Communities engaged with Aboriginal Community Controlled Organisations trained in Safe and Together: Yorgum Healing Services (Yorgum), Wungening Aboriginal Corporation (Wungening) and the Men's Outreach Service Aboriginal Corporation (MOSAC). The three organisations reported that they found the Safe and Together principles and critical components suitable for supporting Aboriginal people and families experiencing family and domestic

violence, in circumstances where engagement is securely underpinned by culturally-informed and trauma-informed practice.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 6: Communities reiterates to the Regional District (including the Crisis Care Unit and after hour services) the role of Communities in facilitating access for Aboriginal people to safe, short stay accommodation options.

Steps taken to give effect to the recommendation

This Office requested that Communities inform the Office of the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> Actions taken by the Regional District
>
> …The Regional District has taken steps to increase Aboriginal people's access to safe accommodation within the District…
>
> Further, the Regional District staff have a good awareness of accommodation providers…, and staff and the broader District maintain a positive relationship with all…services. The Regional District routinely refers Aboriginal people to the services and provides funding for their stays…
>
> Actions taken by SRRS
>
> Following the death…, and since SRRS commenced their statewide function, the SRRS collated information on resources across Western Australia and made them available to staff via a sharepoint site. These resources are accessible by staff to assist vulnerable people, in particular women and survivor/victims of FDV, to access safe accommodation, including after hours.
>
> Further, over 50% of staff in SRRS have completed Safe and Together training, including guidance on assessing FDV and identifying victim/survivors. Staff have an increased understanding about Communities' roles and responsibilities to support vulnerable women to access safe and supported accommodation, particularly after hours.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 7: That, by 1 November 2021, the WA Police Force provides to the Ombudsman a report co-signed by the Department of Communities and a representative of the Remote Aboriginal Community, which details:

- **the dates and outcomes of Joint Response Team (JRT) visits to the Remote Aboriginal Community;**
- **the measures identified by the community, in discussion with the JRT, to improve family and community safety in the Remote Aboriginal Community;**
- **who is responsible for the measures and the anticipated completion date; and**
- **an update on the implementation of the measures to date.**

Steps taken to give effect to the recommendation

WA Police Force provided this office with a letter dated 31 October 2021, co-signed by WA Police Force and Communities, in which this Office was relevantly informed that:

> Communities and WA Police Force acknowledges the disproportionate impact of FDV on Aboriginal women, children, families, and communities and recognises the importance of Community owned and led solutions. FDV is a very serious issue in the Region and Remote Aboriginal Community Lands, where cultural practices are strong and the need for specialist knowledge and skills are required to meet the needs of the Community.
>
> In addition to the agreed initiatives…, the Women within the Remote Aboriginal Community during a recent informal meeting raised a request for a Safe House to be built in the community. No further discussion or decision has been made regarding the request for a Safe House, as further research and consultation is required to understand the full impacts of the suggestions.
>
> As partners of the JRT both agencies remain committed to ongoing visitation and consultation with the Remote Aboriginal Community, whilst remaining flexible to ensure there is due consideration and respect for cultural traditions and events and seasonal community population. Visits to the Community will remain centred around community safety issues including child sexual abuse and family and domestic violence.

The letter dated 31 October 2021 included a report, which confirmed the dates of nine Remote Aboriginal Community visits by the JRT that occurred between August 2020 and December 2021, and actions undertaken during these community visits. The report also outlined two initiatives identified by the Remote Aboriginal Community to improve family and community safety, agreed deliverables and an update on implementation. The report was signed by two representatives of the Remote Aboriginal Community.

This Office requested that WA Police Force inform the Office of any further information on the steps taken to give effect to the recommendation. In response, WA Police Force provided a letter to this Office dated 27 March 2023, containing the following table as an attachment:

Status	Proactive and Reactive actions
Ongoing	Region Detectives Office (RDO) respond to and investigate all reported Child Abuse in the Region District: • A strong working relationship is maintained with the Department of Communities by RDO for child abuse matters and by the Region District Family Violence Team for family violence matters, with the implementation of safety and harm reduction strategies for victims/survivors a priority. • For reports of child abuse, RDO, together with WA Police Force Child Abuse Squad, Child Assessment Interview Team, and Department of Communities, assess the risk, triage and prioritise the response and implement safety strategies for any child at risk of harm. There was one reported incident in 2022. • RDO attend Community (including by air) for any urgent incidents.
Ongoing	Region Police attend Remote Aboriginal Community every three to four weeks, staying approximately three days. The last visit was on 23 February 2023, with five officers remaining in community until 27 February 2023. Officers engage the Remote Community Aboriginal Corporation Community Development Advisor (CDA), Local Aboriginal Health Clinic, the Remote Community school, families and youth and discuss issues, how to improve community family and community safety and safety strategies. Police also engage Remote Aboriginal Community members when they visit Regional town (and reside in town Camp), and Officer in Charge Region maintains regular contact with CDA. Police will attend Remote Aboriginal Community (including by air) for any urgent incidents.
Completed	In May 2022, CCTV and additional lighting were installed in the Remote Aboriginal Community.
Ongoing	RWA Regional Office seeks to increase Region FTE under the growth program to better serve the Remote Aboriginal Community. Considerations for a multi-agency facility in the Remote Aboriginal Community are ongoing. COVID caused significant disruption to the planning of this concept.
Completed	To assist officers to provide a culturally appropriate response: • Region Police have a separate induction for Remote Aboriginal Community outlining cultural issues and mixing officers to maintain continuity and build experience. • Region Detectives are all current in Cultural Awareness training and are encouraged to undertake further studies to increase knowledge and awareness of Childhood trauma. Recent achievements include officers qualified in Childhood Trauma, with one officer having achieved a Post Graduate qualification in Aboriginal Studies.

	• Remote Aboriginal Community language is part of the WA Police Force Yarning app.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

Recommendation 8: That Communities works with the WA Police Force (the lead agency for the JRT) to provide to the Ombudsman by 1 November 2021 a report, co-signed by a representative of the Remote Aboriginal Community, which details:

- **the dates and outcomes of JRT visits to the Remote Aboriginal Community;**
- **the measures identified by the community, in discussion with the JRT, to improve family and community safety in the Remote Aboriginal Community;**
- **who is responsible for the measures and the anticipated completion date; and**
- **an update on the implementation of the measures to date.**

Steps taken to give effect to the recommendation

WA Police Force provided this office with a letter dated 31 October 2021, co-signed by WA Police Force and Communities, in which this Office was relevantly informed that:

> Communities and WA Police Force acknowledges the disproportionate impact of FDV on Aboriginal women, children, families, and communities and recognises the importance of Community owned and led solutions. FDV is a very serious issue in the Region and Remote Aboriginal Community Lands, where cultural practices are strong and the need for specialist knowledge and skills are required to meet the needs of the Community.
>
> In addition to the agreed initiatives…, the Women within the Remote Aboriginal Community during a recent informal meeting raised a request for a Safe House to be built in the community. No further discussion or decision has been made regarding the request for a Safe House, as further research and consultation is required to understand the full impacts of the suggestions.
>
> As partners of the JRT both agencies remain committed to ongoing visitation and consultation with the Remote Aboriginal Community, whilst remaining flexible to ensure there is due consideration and respect for cultural traditions and events and seasonal community population. Visits to the Community will remain centred around community safety issues including child sexual abuse and family and domestic violence.

The letter dated 31 October 2021 included a report, which confirmed the dates of nine Remote Aboriginal Community visits by the JRT that occurred between August 2020 and December 2021, and actions undertaken during these community visits. The report also outlined two initiatives identified by the Remote Aboriginal Community to improve family and community safety, agreed deliverables and an update on implementation. The report was signed by two representatives of the Remote Aboriginal Community.

This Office requested that Communities inform the Office of any further information on the steps taken to give effect to the recommendation. In response, Communities provided a range of information in a letter to this Office dated 23 March 2023, containing a report prepared by Communities.

In Communities' report, Communities relevantly informed this Office that:

> **This recommendation has been actioned.**
>
> Joint Response Team actions to achieve the Ombudsman's recommendation
>
> …WA Police Force sent a report to the Ombudsman, which is co-signed by representatives of the Remote Aboriginal Community, and details:
>
> - the dates and outcomes of the Joint Response Team (JRT) visits to the Remote Aboriginal Community between August 2020 and December 2021; and
> - two measures identified by the Remote Aboriginal Community to improve family and community safety:
>   - plans for the installation of lighting and security cameras in the Remote Aboriginal Community by the Shire, which was an approved schedule of works to be completed in the 2021-2022 financial year.
>   - plans for Communities to be responsible for the JRT delivering 'culturally appropriate Protective Behaviours resources' with the Remote Aboriginal Community, from November 2021.
>
> …the following progress has been made to achieve the two measures identified by the Remote Aboriginal Community to improve family and community safety:
>
> - lighting and security cameras have now been installed near the women's centre and can be viewed from the community office; and
> - when the JRT visited the Remote Aboriginal Community in February 2022, Protective Behaviours was delivered in the local school.
>
> …
>
> Joint Response Team – other actions
>
> Since the Progress Update provided to the Ombudsman…, the JRT attended the Remote Aboriginal Community on three occasions, from 8 to 10 November 2021, 6 to 8 December 2021 and 14 to 17 February 2022.
>
> Communities have not undertaken any further visits to the Remote Aboriginal Community since February 2022, due to:
>
> - COVID outbreaks in the community…;
> - Communities' staff illness which prevented Communities from accompanying WA Police on a visit to the community in March 2022; and
> - the Senior Child Protection Worker – FDVRT who had led the previous visits to the Community is currently acting as the Team Leader for the Goldfields District Child Safety Team. The Senior Child Protection Worker – FDVRT position has remained vacant despite ongoing attempts to recruit to the position.
>
> It was planned for the Communities' Regional Executive Director and Aboriginal Practice Leader to travel to the Community in September 2022, to further consult the Community about their needs and views. This visit did not eventuate due to cultural business being undertaken in the community at the time and the community not wanting the visit to occur.

The Regional District have held some concerns about whether the JRT visits are welcomed by the community, whether the visits are achieving the purpose of promoting women and children's safety and whether the JRT visits have the potential to increase risks for FDV survivor safety…Women have expressed that they do not want meetings happening in the community, however talked about going out bush instead. In response to this feedback, during one visit workers did meet with some elder women out bush to cook damper and roo tail and speak about what was happening in the community.

The Regional District Leadership Team, including the Aboriginal Practice Leader, have held internal discussions in relation to how the Remote Aboriginal Community's safety can be best promoted via meeting with women outside of the community. These discussions are ongoing.

…

Region FDV Plan

A working group consisting of Communities and external stakeholders are currently developing a Project Plan for the Region FDV plan, which will seek to reduce FDV across the Regional District. The Plan will outline strategies and recommendations for how FDV will be reduced, and safety increased, across the Region.

As part of the development of the plan, Communities will undertake consultations with the Remote Aboriginal Community.

Following careful consideration of the information provided, steps have been taken to give effect to this recommendation.

The Office will continue to monitor, and report on, the steps being taken to give effect to the recommendations including through the undertaking of reviews of family and domestic violence fatalities and in the undertaking of major own motion investigations.

Timely Handling of Notifications and Reviews

The Office places a strong emphasis on the timely review of family and domestic violence fatalities. This ensures reviews contribute, in the most timely way possible, to the prevention or reduction of future deaths. In 2022-23, timely review processes have resulted in 44% of all reviews being completed within six months and 68% of reviews completed within 12 months.

Major Own Motion Investigations Arising from Family and Domestic Violence Fatality Reviews

In addition to investigations of individual family and domestic violence fatalities, the Office identifies patterns and trends arising out of reviews to inform major own motion investigations that examine the practice of public authorities that provide services to children, their families and their communities.

Details of own motion investigations are provided in the Own Motion Investigations, Monitoring and Improvement section.

Investigation into Family and Domestic Violence and Suicide

On Thursday 20 October 2022, the Ombudsman tabled in Parliament the report of his major own motion investigation titled *Investigation into family and domestic violence and suicide*. Arising from the findings of the investigation, the Ombudsman made nine recommendations to four government agencies about ways to prevent or reduce family and domestic violence related deaths by suicide.

Further details of this report is provided in the Own Motion Investigations, Monitoring and Improvement section.

The full report, *Investigation into family and domestic violence and suicide*, is available at: www.ombudsman.wa.gov.au/Publications/Reports/FDV-Suicide-2022-Volumes-1-to-4.pdf

Monitoring recommendations from major own motion investigations

The Office actively monitors the steps taken to give effect to recommendations arising from own motion investigations, including:

- *Investigation into family and domestic violence and suicide*, which was tabled in Parliament in October 2022; and
- *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, which was tabled in Parliament in November 2015.

Details of the Office's monitoring of the steps taken to give effect to recommendations arising from own motion investigations are provided in the Own Motion Investigations, Monitoring and Improvement section.

On 19 November 2015, the Ombudsman tabled in Parliament a report entitled *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*. Recommendation 54 of the report is as follows:

> Taking into account the findings of this investigation, DCPFS:
>
> - conducts a review to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance;
> - develops an associated action plan to overcome identified barriers; and
> - provides the resulting review report and action plan to this Office within 12 months of the tabling in the Western Australian Parliament of the report of this investigation.

Section 25(4) of the *Parliamentary Commissioner Act 1971* relevantly provides as follows:

> (4) If under subsection (2) the Commissioner makes recommendations to the principal officer of an authority he may request that officer to notify him, within a specified time, of the steps that have been or are proposed to be taken to give effect to the recommendations, or, if no such steps have been, or are proposed to be taken, the reasons therefor.

On 13 October 2016, the Director General of the (then) Department for Child Protection and Family Support (**DCPFS**) provided the Ombudsman with two documents constituting DCPFS's response to Recommendation 54. These were the *Family and Domestic Violence Practice Guidance Review Report* and the *Family and Domestic Violence – Practice Guidance Implementation*.

On 10 November 2016, the Ombudsman tabled in Parliament *A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, which, among other things, identified that:

> The review report and action plan have been provided to the Office within 12 months of the tabling of the FDV Investigation Report, and will be reviewed by the Office and the results of this review reported on in the Office's 2016-17 Annual Report.

In the Office's *Annual Report 2016-17*, the Office identified that (the then) DCPFS's response to Recommendation 54 had been reviewed and that the Office's analysis would be tabled separately.

The Office has now concluded its review of the (now) Department of Communities' (**Communities**) review report. The Office has considered the *Family and Domestic Violence Practice Guidance Review Report* and that Communities has conducted a project to review its family and domestic violence practice guidance. The focus of the review conducted by Communities was to identify and recommend amendments to Communities' family and domestic violence practice guidance. The review did not include any actions 'to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance'. Further, while Communities identified several issues which potentially relate to barriers to effective implementation, a range of Communities' 'proposed actions' to overcome these potential barriers were not considered to be appropriate.

Following consideration of all of the above matters, the review conducted by Communities did not constitute a review to identify barriers to the effective implementation of relevant family and domestic violence policies and practice guidance. As developing an associated action plan to overcome identified barriers was contingent on conducting a review to identify those barriers, the *Family and Domestic Violence – Practice Guidance Implementation* document did not constitute an associated action plan to overcome identified barriers.

In a pleasing response to this finding, Communities indicated the following:

> Communities acknowledges this finding and confirms it is a priority for Communities to address and implement the intent of the recommendation. It was the intent of the *Family and Domestic Violence Practice Guidance Review Report* (the report) and the *Family and Domestic Violence Practice Guidance Implementation* to do so. The report did help to identify a range of issues that limit the implementation of policy and practice guidance, and Communities has undertaken numerous activities and processes to address these. These include:
>
> - new toolkits for assessment and safety planning in cases of emotional abuse - family and domestic violence, which aim to support child protection workers to form an evidence-based professional judgement, and include practice examples of how to gather information to inform assessments, analyse the information, and practice examples of safety planning;
> - mandatory training concerning family and domestic violence for new and current employees to have a focus on effectively engaging perpetrators, including assessments within the training and in the field;
> - workshops and presentations with Team Leader and Senior Practice Development Officer groups to encourage strong leadership within districts of the policy and practice guidance;

- case consultation with child protection workers to provide opportunities for staff to reflect on and plan their practice;
- a centralised intake model in July 2017, including a 'threshold tool' to provide a consistent response to child protection referrals;
- a partnership with Curtin University, the University of Melbourne and the Safe and Together Institute in order to integrate techniques in working with perpetrators into practice; and
- a practice audit is currently being undertaken to assess the implementation to date of the family and domestic violence practice guidance, and to establish a baseline from which further audits or reviews of practice can be measured. The audit examines 50 cases (three from each district) at various stages of Communities' Child Protection and Family Support division involvement, identifies areas for practice improvement and provides opportunities to work with districts to improve understanding of key issues in the intersection between child protection and family and domestic violence.

Other Mechanisms to Prevent or Reduce Family and Domestic Violence Fatalities

In addition to reviews of individual family and domestic violence fatalities and major own motion investigations, the Office uses a range of other mechanisms to improve public administration with a view to preventing or reducing family and domestic violence fatalities. These include:

- Assisting public authorities by providing information about issues that have arisen from family and domestic violence fatality reviews, and enquiries and complaints received, that may need their immediate attention, including issues relating to the safety of other parties;
- Through working with public authorities and communities where individuals may be at risk of family and domestic violence to consider safety issues and potential areas for improvement, and to highlight the critical importance of effective liaison and communication between and within public authorities and communities;
- Exchanging information, where appropriate, with other accountability and oversight agencies including Ombudsmen and family and domestic violence fatality review bodies in other States to facilitate consistent approaches and shared learning;
- Engaging with other family and domestic violence fatality review bodies in Australia through membership of the Australian Domestic and Family Violence Death Review Network (**the Network**). The Network worked in partnership with the Australia's National Research Organisation for Women's Safety (**ANROWS**) to publish the *Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010-2018, Second Edition 2022*. This collaboration is also working to develop a national dataset of the characteristics of the deaths of children by parents to inform prevention initiatives at a national level;
- Undertaking or supporting research that may provide an opportunity to identify good practices that may assist in the prevention or reduction of family and domestic violence fatalities; and
- Taking up opportunities to inform service providers, other professionals and the community through presentations.

Stakeholder Liaison

Efficient and effective liaison has been established with WA Police Force to develop and support the implementation of the process to inform the Office of family and domestic violence fatalities. Regular liaison occurs at senior officer level between the Office and WA Police Force.

Key stakeholder relationships

There are a number of public authorities and other bodies that interact with or deliver services to those who are at risk of family and domestic violence or who have experienced family and domestic violence. Important stakeholders, with which the Office liaised as part of the family and domestic violence fatality review function in 2021-22, included:

- The Coroner;
- Relevant public authorities including:
  - WA Police Force;
  - The Department of Health;
  - Health Service Providers;
  - The Department of Education;
  - The Department of Justice;
  - The Department of Communities;
  - The Mental Health Commission; and
  - Other accountability and similar agencies including the Commissioner for Children and Young People;
- The Centre for Women's Safety and Wellbeing and relevant non-government organisations; and
- Research institutions including universities.

Aboriginal and regional communities

In 2016, the Ombudsman established a Principal Aboriginal Consultant position to:

- Provide high level advice, assistance and support to the Corporate Executive and to staff conducting reviews and investigations of the deaths of certain Aboriginal children and family and domestic violence fatalities in Western Australia, complaint resolution involving Aboriginal people and own motion investigations; and
- Raise awareness of and accessibility to the Ombudsman's roles and services to Aboriginal communities and support cross cultural communication between Ombudsman staff and Aboriginal people.

In 2022-23, the Ombudsman created a critical new executive position, Assistant Ombudsman Aboriginal Engagement and Collaboration, which was filled by Laurence Riley in August 2022. This is the first time in the fifty year history of the Office that an Assistant Ombudsman position, and member of Corporative Executive, has been dedicated to Aboriginal Western Australians.

Significant work was undertaken throughout 2022-23 to continue to build relationships relating to the child death review jurisdiction with Aboriginal and regional communities, for example by communicating with:

- Key public authorities that work in regional areas;
- Non-government organisations that provide key services, such as health services to Aboriginal people; and
- Aboriginal community members and leaders to increase the awareness of the child death review function and its purpose.

Additional networks and contacts have been established to support effective and efficient child death reviews. This has strengthened the Office's understanding and knowledge of the issues faced by Aboriginal and regional communities that impact on child and family wellbeing and service delivery in diverse and regional communities.

Own Motion Investigations, Monitoring and Improvement

A key function of the Office is to improve the standard of public administration. The Office achieves positive outcomes in this area in a number of ways including:

- Improvements to public administration as a result of:
  - The investigation of complaints;
  - Reviews of certain child deaths and family and domestic violence fatalities; and
  - Undertaking own motion investigations that are based on the patterns, trends and themes that arise from the investigation of complaints, and the review of certain child deaths and family and domestic violence fatalities;
- Undertaking inspection and monitoring functions;
- Providing guidance to public authorities on good decision making and practices and complaint handling through continuous liaison, publications, presentations and workshops; and
- Working collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities.

Improvements from Complaints and Reviews

In addition to outcomes which result in some form of assistance for the complainant, the Ombudsman also achieves outcomes which are aimed at improving public administration. Among other things, this reduces the likelihood of the same or similar issues which gave rise to the complaint occurring again in the future. Further details of the improvements arising from complaint resolution are shown in the Complaint Resolution section.

Child death and family and domestic violence fatality reviews also result in improvements to public administration as a result of the review of individual child deaths and family and domestic violence fatalities. Further details of the improvements arising from reviews are shown in the Child Death Review section and the Family and Domestic Violence Fatality Review section.

Own Motion Investigations

One of the ways that the Office endeavours to improve public administration is to undertake investigations of systemic and thematic patterns and trends arising from

complaints made to the Ombudsman and from child death and family and domestic violence fatality reviews. These investigations are referred to as own motion investigations.

Own motion investigations are intended to result in improvements to public administration that are evidence-based, proportionate, practical and where the benefits of the improvements outweigh the costs of their implementation.

Own motion investigations that arise out of child death and family and domestic violence fatality reviews focus on the practices of agencies that interact with children and families and aim to improve the administration of these services to prevent or reduce child deaths and family and domestic violence fatalities.

Selecting topics for own motion investigations

Topics for own motion investigations are selected based on a number of criteria that include:

- The number and nature of complaints, child death and family and domestic violence fatality reviews, and other issues brought to the attention of the Ombudsman;
- The likely public interest in the identified issue of concern;
- The number of people likely to be affected;
- Whether reviews of the issue have been done recently or are in progress by the Office or other organisations;
- The potential for the Ombudsman's investigation to improve administration across public authorities; and
- Whether investigation of the chosen topic is the best and most efficient use of the Office's resources.

Having identified a topic, extensive preliminary research is carried out to assist in planning the scope and objectives of the investigation. A public authority selected to be part of an own motion investigation is informed when the project commences and Ombudsman staff consult regularly with staff at all levels to ensure that the facts and understanding of the issues are correct and findings are evidence-based. The public authority is given regular progress reports on findings together with the opportunity to comment on draft conclusions and any recommendations.

Own Motion Investigations in 2022-23

In 2022-23, significant work was undertaken on:

- A report on giving effect to the recommendations arising from the *Investigation into the handling of complaints by the Legal Services and Complaints Committee*, which was tabled in Parliament in September 2022;
- A report on giving effect to the recommendations arising from *An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley*, which was tabled in Parliament in October 2022;
- Investigation into family and domestic violence and suicide, which was tabled in Parliament in October 2022; and
- A report on giving effect to the recommendations arising from the *Investigation into family and domestic violence and suicide*, to be tabled in Parliament in 2023.

Investigation into family and domestic violence and suicide

On 20 October 2022, the Ombudsman tabled in Parliament the report of his major own motion investigation titled *Investigation into family and domestic violence and suicide*.

The investigation commenced following the Ombudsman's identification of the need to undertake a major own motion investigation into family and domestic violence and suicide while undertaking his important responsibilities of reviewing family and domestic violence fatalities and child deaths.

To undertake this investigation, in addition to an extensive literature review and stakeholder engagement, the Office collected and analysed a comprehensive set of state-wide data relating to those who died by suicide in circumstances where family and domestic violence had previously been identified by one or more State government departments or authorities. This included an examination of 68 women and child victims of family and domestic violence who died by suicide in 2017.

The Ombudsman found that a range of work has been undertaken by State government departments and authorities to administer their relevant legislative responsibilities to support the safety of women and children experiencing family and domestic violence. The Ombudsman found, however, that there is important further work that should be done, including a range of important opportunities for improvement for State government departments and authorities, working individually and collectively, across all stages of the service spectrum to improve the identification of, and responses to, family and domestic violence in Western Australia.

In addition, this investigation identified the need for State government departments and authorities to use a trauma informed approach when working with people who have experienced multiple circumstances of vulnerability, including in responding to family and domestic violence and suicidality.

Arising from the findings of the investigation, the Ombudsman made nine recommendations to four government agencies about ways to prevent or reduce family and domestic violence related deaths by suicide. The Ombudsman is very pleased that each agency has agreed to these recommendations.

The full report, *Investigation into family and domestic violence and suicide*, is available at: www.ombudsman.wa.gov.au/Publications/Reports/FDV-Suicide-2022-Volumes-1-to-4.pdf

The Office is monitoring the steps taken to give effect to the recommendations of *Investigation into family and domestic violence and suicide* and in accordance with the Ombudsman's commitment to Parliament, will report on the results of our monitoring in 2023.

Monitoring the implementation of recommendations

Recommendations for administrative improvements are based closely on evidence gathered during investigations and are designed to be a proportionate response to the number and type of administrative issues identified. Each of the recommendations arising from own motion investigations is actively monitored by the Office to ensure its implementation and effectiveness in relation to the observations made in the investigation.

A report on giving effect to the recommendations arising from the *Investigation into the handling of complaints by the Legal Services and Complaints Committee*

About the report

On 21 September 2022, the Ombudsman released his report on giving effect to the recommendations arising from the *Investigation into the handling of complaints by the Legal Services and Complaints Committee.*

Following a request to the Ombudsman by the Honourable John Quigley MLA, Attorney General, to consider the handling of complaints by the Legal Profession Complaints Committee (**the LPCC**), the Ombudsman completed an investigation into the handling of complaints by the LPCC on 11 December 2020.

In the report of the investigation, the Ombudsman set out a series of opinions regarding the handling of complaints by the LPCC. Arising from these opinions, the Ombudsman made thirteen recommendations to the LPCC. This report sets out the steps taken by the now Legal Services and Complaints Committee (**LSCC**) to give effect to the Ombudsman's recommendations.

The report is available at:

www.ombudsman.wa.gov.au/Publications/Reports/Legal-Services-and-Complaints-Committee-Report-September-2022.pdf

Objectives

The objectives of this report were to consider (in accordance with the *Parliamentary Commissioner Act 1971*):

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations; or
- If no such steps have been, or are proposed to be taken, the reasons therefor.

This report also considered whether the steps taken, proposed to be taken or reasons for taking no steps:

- Seem to be appropriate; and
- Have been taken within a reasonable time of the making of the recommendations.

Methodology

On 23 July 2021, the Office wrote to the LSCC, requesting a report on the steps that have been taken, or were proposed to be taken, to give effect to the recommendations of the report. Additionally, the Office:

- Reviewed and considered the information provided by the LSCC and the information, clarification or validation provided to the Office;

- Obtained further information from the LSCC, in order to clarify or validate information provided in the LSCC's report to the Office;
- Developed a preliminary view and provided it to the LSCC for its consideration and response; and
- Having fully considered the responses of the LSCC, developed a final report.

Summary of Findings

In the report of the investigation, the Ombudsman identified serious problems with the timeliness of the LSCC's handling of complaints as well as its lack of key performance indicators, inadequate public reporting and lack of a modern electronic system for complaints management. Accordingly, it is pleasing that the response to the report by the LSCC has been timely and effective.

Following over a decade of indications that the LSCC would institute an electronic complaints management system, in the report the Ombudsman recommended (Recommendation 13) that the LSCC implement an electronic complaints management system by no later than the end of the financial year 2021-22 and should aim to do so by December 2021. The LSCC has given effect to the Ombudsman's recommendation and implemented an electronic complaints management system, slightly ahead of the time the Ombudsman recommended, ending over a decade of delay. In the report, the Ombudsman further recommended (Recommendation 2) that the LSCC achieved the closure of very aged complaints. Again, the LSCC has done so, and again ahead of the time that the Ombudsman recommended.

Overall, the LSCC has either given effect, taken steps to give effect, or steps have been proposed to give effect, to all thirteen recommendations in the report.

A report on giving effect to the recommendations arising from *An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley*

About the report

On 18 October 2022, the Ombudsman released his report on giving effect to the recommendations arising from *An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley*.

On 2 March 2021, the Honourable John Quigley MLA, Attorney General, wrote to the Ombudsman requesting an investigation into the Office of the Public Advocate's (**OPA**) role in notifying the family of Mrs Joyce Savage of the death of Mrs Savage. The Attorney General also requested that the Ombudsman include in his investigation, the circumstances of OPA's notification to the families of Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mr Ayling and Mr Hartley.

On the same day, in accordance with section 16(1) of the *Parliamentary Commissioner Act 1971*, the Ombudsman initiated an investigation into OPA's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

As a result of the investigation, the Ombudsman formed a number of opinions regarding OPA's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley.

Arising from these opinions, the Ombudsman made seven recommendations to OPA. This report sets out the steps taken by OPA to give effect to the Ombudsman's recommendations.

The report is available at:

www.ombudsman.wa.gov.au/Improving_Admin/Publications/Reports/Office-of-the-Public-Advocate-Report-October-2022.pdf

Objectives

The objectives of this report were to consider (in accordance with the *Parliamentary Commissioner Act 1971*):

- The steps that have been taken to give effect to the recommendations;
- The steps that are proposed to be taken to give effect to the recommendations; or
- If no such steps have been, or are proposed to be taken, the reasons therefor.

This report also considered whether the steps taken, proposed to be taken or reasons for taking no steps:

- Seem to be appropriate; and
- Have been taken within a reasonable time of the making of the recommendations.

Methodology

On 16 March 2022, the Ombudsman wrote to the Public Advocate, requesting a report on the steps that have been taken, or were proposed to be taken, to give effect to the recommendations of the report.

Additionally, the Office:

- Obtained further information from OPA, in order to clarify or validate information provided in OPA's report to the Office;
- Reviewed and considered the information provided by OPA and the information, clarification or validation provided to the Office;
- Developed a preliminary view and provided it to OPA for its consideration and response; and
- Developed a final report.

Summary of Findings

Having very carefully considered the information provided by OPA regarding their implementation of the seven recommendations, the Ombudsman is pleased to report that OPA has taken steps to give effect to each of the seven recommendations. In no instance did the Ombudsman find that no steps have been taken to give effect to a recommendation. This is an important and pleasing outcome.

The Ombudsman is also pleased to report that the Public Advocate and her staff have been highly cooperative, open and timely during the undertaking of the investigation and this report. A preparedness to accept oversight and accountability and take positive steps to improve the provision of their essential services to some of Western Australia's most vulnerable citizens reflects very well on OPA.

Inspection and Monitoring Functions

Inspection of telecommunications interception records

The *Telecommunications (Interception and Access) Western Australia Act 1996*, the *Telecommunications (Interception and Access) Western Australia Regulations 1996* and the *Telecommunications (Interception and Access) Act 1979* (Commonwealth) permit designated 'eligible authorities' to carry out telecommunications interceptions. The Western Australia Police Force (**WA Police Force**) and the Corruption and Crime Commission are eligible authorities in Western Australia. The Ombudsman is appointed as the Principal Inspector to inspect and report on the extent of compliance with the legislation.

Monitoring of the *Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021*

On 24 December 2021, the *Criminal Law (Unlawful Consorting and Prohibited Insignia) Act 2021* (**the Act**) was promulgated. This is an Act to:

- Make consorting unlawful between certain offenders;
- Provide for the identification of organisations for the purposes of the Act;
- Prohibit the display in public places of insignia of identified organisations;
- Provide for the issue of dispersal notices to members of identified organisations and make any consorting contrary to those notices unlawful;
- Provide for police powers relating to unlawful consorting and insignia of identified organisations; and
- Make consequential and other amendments to the *Community Protection (Offender Reporting) Act 2004* and *The Criminal Code*.

Parts 2 and 3 of the Act provide for unlawful consorting notices, insignia removal notices, display of prohibited insignia, dispersal notices and the use of police powers and criminal charges relating to these parts.

Part 4 of the Act provides that the Ombudsman must keep the exercise of powers conferred under the Act under scrutiny. Further, the Ombudsman must inspect the records of WA Police Force in order to ascertain the extent of WA Police Force's compliance with Parts 2 and 3 of the Act.

The Commissioner of Police must keep a register (**the register**) of the issue and service of all notices under the Act, the revocation or variation of any notice issued and served under the Act, any prosecution for an offence under the Act, the use of any police powers whilst operationalising the Act and any certificate of service given under the Act. The Commissioner of Police must provide the register to the Ombudsman.

Further, under Part 4 of the Act, the Ombudsman must report annually on the monitoring activities undertaken as soon as practicable after each anniversary of the day on which Part 4 came into operation. The Ombudsman must provide a copy of the annual report to the responsible Minister and the Commissioner of Police.

The annual report may include any observations that the Ombudsman considers appropriate to make about the operation of the Act and must include any recommendations made by the Ombudsman and details of any actions taken by the Commissioner of Police in respect of any recommendations. The annual report must include any information contained in the register. The annual report must also include

a review of the impact of the operation of the Act on a particular group in the community if such an impact came to the attention of the Ombudsman.

The Minister must cause the annual report to be tabled in Parliament within 12 sitting days after the Minister receives a copy of the report.

Monitoring of Protected Entertainment Precincts

The *Liquor Control Act 1988* (**the Liquor Control Act**) was amended through the *Liquor Control Amendment (Protected Entertainment Precincts) Act 2022 (***the Amendment Act***)* to provide for the establishment of Protected Entertainment Precincts and for the exclusion of people from a precinct who behave in an unlawful, anti-social, violent, disorderly, offensive, indecent or threatening way, or are convicted of specified serious offences, which occurred in the precinct. The Amendment Act received Royal Assent on 1 December 2022 with Part 5AA of the Act (containing the protected entertainment precincts provisions) commencing on 24 December 2022.

Under the Liquor Control Act, the Ombudsman must keep under scrutiny the operation of, and the exercise of powers under the provisions of Part 5AA of the Liquor Control Act, any regulations made for the purposes of Part 5AA and any regulations made to prescribe an area of the State to be a Protected Entertainment Precinct.

As soon as practicable after the third anniversary of the day on which Part 5AA of the Liquor Control Act comes into operation, the Ombudsman must prepare a report on the Ombudsman's monitoring work and activities and give a copy of the report to the Minister and to the Commissioner of Police.

The report must, if the Ombudsman has identified any group in the community that is particularly affected by the operation of, or the exercise of powers under the provisions of this new law, include a review of the impact of the operation of, and the exercise of powers under, those provisions on that group. The report may also include recommendations about amendments that might appropriately be made to the Liquor Control Act.

The Ombudsman may at any other time considered appropriate, prepare a report on the Ombudsman's work and activities and give a copy of the report to the Minister and the Commissioner of Police.

The Minister must cause a report to be tabled in Parliament as soon as practicable after the Minister received the report.

Continuous Administrative Improvement

The Office maintains regular contact with staff from public authorities to inform them of trends and issues identified in individual complaints and the Ombudsman's own motion investigations with a view to assisting them to improve their administrative practices. This contact seeks to encourage thinking around the foundations of good administration and to identify opportunities for administrative improvements.

Where relevant, these discussions concern internal investigations and complaint processes that authorities have conducted themselves. The information gathered demonstrates to the Ombudsman whether these internal investigations have been conducted appropriately and in a manner that is consistent with the standards and practices of the Ombudsman's own investigations.

Guidance for Public Authorities

The Office provides publications, workshops, assistance and advice to public authorities regarding their decision making and administrative practices and their complaint handling systems. This educative function assists with building the capacity of public authorities and subsequently improving the standard of administration.

Publications

The Ombudsman has a range of guidelines available for public authorities in the areas of effective complaint handling, conducting administrative investigations and administrative decision making. These guidelines aim to assist public authorities in strengthening their administrative and decision making practices. For a full listing of the Office's publications, see Appendix 3.

Workshops for public authorities

During the year, the Office continued to proactively engage with public authorities through presentations and workshops.

A workshop for public authorities was held in Karratha in May 2023. Workshops are targeted at people responsible for making decisions or handling complaints as well as customer service staff. The workshops are also relevant for supervisors, managers, senior decision and policy makers as well as integrity and governance officers who are responsible for implementing and maintaining complaint handling systems or making key decisions within a public authority.

The workshops are tailored to the organisation or sector by using case studies and practical exercises. Details of workshops conducted during the year are provided in the Collaboration and Access to Services section.

Working collaboratively

The Office works collaboratively with other integrity and accountability agencies to encourage best practice and leadership in public authorities. Improvements to public administration are supported by the collaborative development of products and forums to promote integrity in decision making, practices and conduct. Details are provided in the Collaboration and Access to Services section.

Reportable Conduct Scheme

Background

The *Royal Commission into Institutional Responses to Child Sexual Abuse* (**the Royal Commission**) highlighted the numerous times and ways in which children reported abuse and were not believed, or no action was taken. The Royal Commission recommended that States and Territories establish Reportable Conduct Schemes to prevent harm to children by holding organisations accountable for the conduct of their staff.

Reportable Conduct Schemes support people to speak up about concerning behaviours, helps prevent child abuse and improve systems and processes of organisations for preventing and dealing with complaints and reports of abuse about their staff.

Western Australia's Reportable Conduct Scheme (**Scheme**) commenced on 1 January 2023, following amendments to the *Parliamentary Commissioner Act 1971* (**Act**).

The Scheme makes Western Australian children safer.

The Scheme compels heads of organisations that exercise care, supervision or authority over children to notify allegations of, or convictions for, child abuse by their employees to the Ombudsman and then investigate these allegations. The Ombudsman monitors, oversees and reviews these investigations. The requirement for the head of the organisation to undertake an investigation and take appropriate action protects children by ensuring their complaints are not dismissed, minimised, ignored or mishandled and, where appropriate, action is taken to prevent further reportable conduct. It will further reinforce the responsibility that institutions must take to ensure the safety of children.

The Ombudsman will also be able to share information where appropriate to better prevent and protect children from abuse, this includes with the Working with Children Screening Unit of the Department of Communities, relevant regulators and the WA Police Force.

Over 2,800 organisations across Western Australia have this reporting obligation.

The Scheme implements key recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse and provides that child abuse in organisations will be:

- notified to an impartial and independent body;
- investigated fully; and
- dealt with to ensure children are protected from abuse within institutions.

Information regarding reporting

This chapter of the Annual Report provides information regarding the first six months of the operation of the Scheme. The annual reporting of the work of the Office on the Scheme will be developed and considerably expanded over future annual reports. This will include deidentified case studies and extensive further information and systemic analysis over time arising from the Scheme. This approach is consistent with the commencement of the Child Death Review and Family and Domestic Violence Fatality Reviews functions by the office of the Ombudsman, which now, properly, at nearly 120 pages, constitute over 40% of the Office's Annual Report.

What is the Reportable Conduct Scheme?

The Scheme compels heads of organisations that exercise care, supervision or authority over children to notify allegations of, or convictions for, child abuse by their employees to the Ombudsman and then investigate these allegations. The Ombudsman will monitor, oversee and review these investigations.

The objects of the Scheme are set out in section 19J(1) of the Act, as follows:

> (1) The object of this Division is protect children from harm by establishing and implementing a scheme for: -
>
> (a) preventing reportable conduct;
>
> (b) reporting, notifying and investigating reportable allegations and reportable convictions; and
>
> (c) taking appropriate action in response to findings of reportable conduct.

'Reportable conduct' is defined in section 19G of the Act as follows:

> (1) ***Reportable conduct*** is the following conduct, whether or not a criminal proceeding in relation to the conduct has been commenced or concluded and whether the conduct occurred before, on or after commencement day –
>
> (a) a sexual offence;
>
> (b) sexual misconduct;
>
> (c) a physical assault committed against, with or in the presence of, a child;
>
> (d) an offence prescribed by the regulations for the purposes of this paragraph.
>
> (2) However, ***reportable conduct*** does not include conduct that is –
>
> (e) reasonable for the discipline, management or care of a child or of another person in the presence of a child, having regard to –

(i) the characteristics of the child, including the age, health and developmental stage of the child; and

(ii) any relevant code of conduct or professional standard that at the time applied to the discipline, management or care of the child or the other person;

or

(f) trivial or negligible and that has been or will be investigated and recorded as part of another workplace procedure; or

(g) of a class or kind exempt from being reportable conduct under section 19N(1).

(3) For the purposes of this section, conduct includes an act or omission.

The terms 'reportable allegation' and 'reportable conviction' are defined in sections 19F and 19H of the Act, respectively, as set out below:

19F. Reportable allegation

(1) A ***reportable allegation*** is any information that leads a person to form the belief on reasonable grounds that an employee of a relevant entity has engaged in reportable conduct or conduct that may involve reportable conduct, whether or not the conduct is alleged to have occurred in the course of the employee's employment.

(2) However, a ***reportable allegation*** does not include information relating to a reportable conviction.

19H. Reportable conviction

(1) A ***reportable conviction*** is a conviction, whether before, on or after commencement day, for an offence under a law of this State, another State, a Territory or the Commonwealth that is an offence referred to in section 19G(1)(a) or (d).

(2) For the purposes of subsection (1), a ***conviction*** for an offence committed by a person is a reference to any of the following –

(a) a court making a formal finding of guilt in relation to the offence;

(b) if there has been no formal finding of guilt before conviction – a court convicting the person of the offence;

(c) a court accepting a plea of guilty from the person in relation to the offence;

(d) a court acquitting the person following a finding under *The Criminal Code* section 27 that the person is not guilty of the offence on account of unsoundness of mind or an acquittal following an equivalent finding under a law of another State, a Territory or the Commonwealth.

(3) For the purposes of subsection (1), a reference to a ***conviction*** includes a reference to a conviction that is a spent conviction.

(4) For the purpose of subsection (3), an offence becomes spent if, under a law of this State, another State, a Territory or the Commonwealth, the person concerned is permitted not to disclose the fact that the person was convicted or found guilty of the offence.

(5) For the purposes of subsection (1), a reference to a ***conviction*** does not include a reference to a conviction that is subsequently quashed or set aside by a court.

The role of the Ombudsman under the Reportable Conduct Scheme

The role of the Ombudsman under the Scheme is comprised of the following functions, set out in section 19M(1) of the Act:

(a) to oversee and monitor the reportable conduct scheme;

(b) to educate and provide advice to relevant entities in order to assist them to identify and prevent reportable conduct and to notify and investigate reportable allegations and reportable convictions;

(c) to support relevant entities to make continuous improvement in the identification and prevention of reportable conduct and the reporting, notification and investigation of reportable allegations and reportable convictions;

(d) to monitor the investigation of reportable allegations and reportable convictions by relevant entities;

(e) if the Commissioner considers it to be in the public interest to do so – to investigate reportable allegations and reportable convictions;

(f) if the Commissioner considers it to be in the public interest to do so – to investigate whether reportable allegations or reportable convictions have been appropriately handled or investigated or responded to by the head of a relevant entity;

(g) to make recommendations to relevant entities in relation to the findings of the investigations referred to in paragraph (e) or (f);

(h) to monitor the compliance of relevant entities with the reportable conduct scheme and whether appropriate and timely action is taken by a relevant entity;

(i) to monitor a relevant entity's systems for preventing, notifying and dealing with reportable conduct;

(j) to report to Parliament on the reportable conduct scheme;

(k) to perform any other function conferred on the Commissioner under this Division.

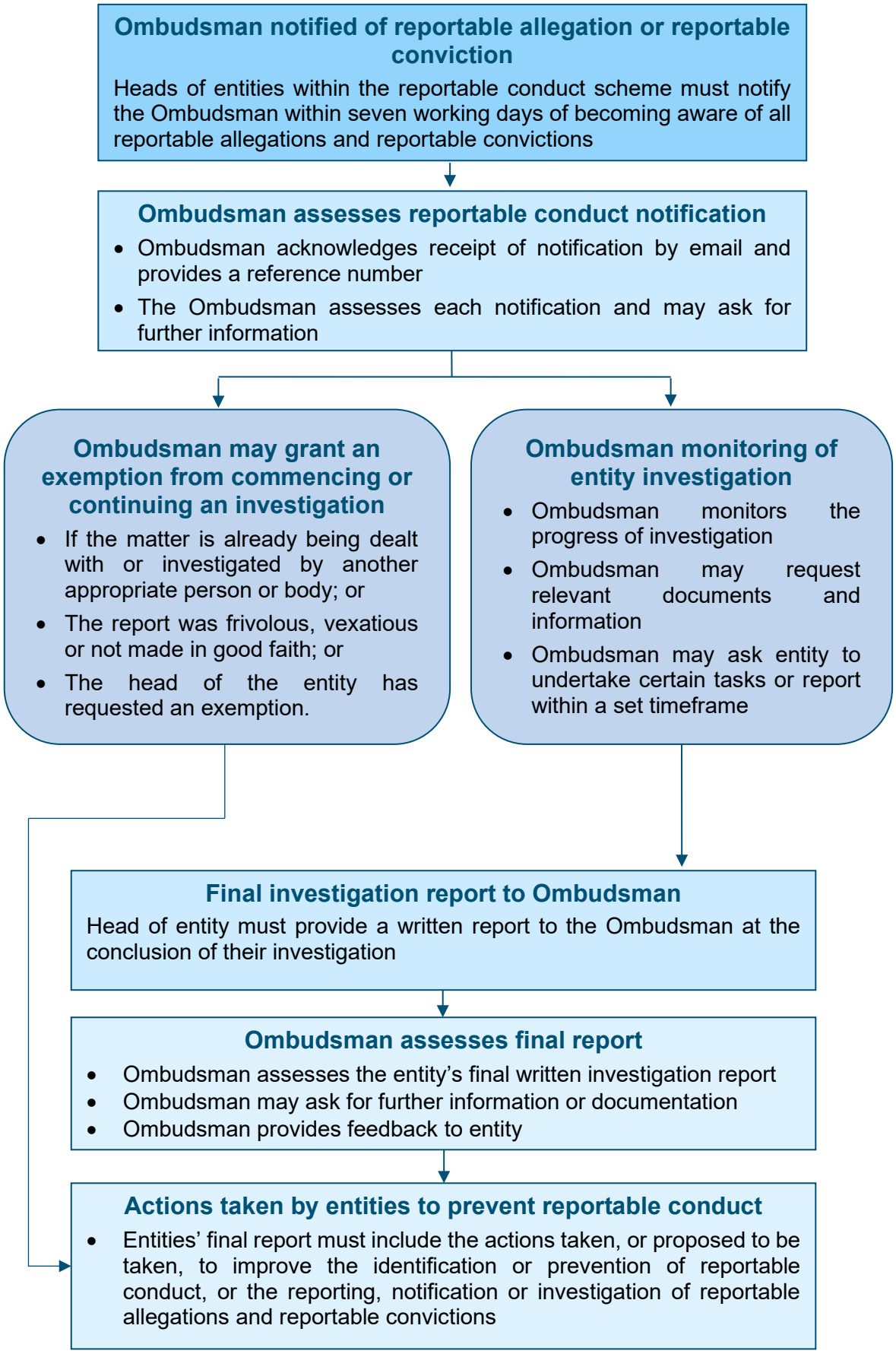
In undertaking his role under the Scheme, the Ombudsman is required to regard the best interests of children as the paramount consideration, under section 19K of the Act:

> **19K. Paramount consideration**
>
> The Commissioner [Ombudsman] and any other person performing functions under this Division must regard the best interest of children as the paramount consideration.

'Employee' is defined broadly under the Scheme, and includes contractors, volunteers, carers of children in placement arrangements under the *Children and Community Services Act 2004*, family day care educators and educator assistants, police officers, and people otherwise engaged by the relevant entity to provide services to children.

If the head of a relevant entity becomes aware of a reportable allegation or conviction involving an employee, they must provide an initial written notification to the Ombudsman within seven working days. Organisations also have additional reporting obligations on completion of their reportable conduct investigation. The Office may require further information from an organisation; can exercise investigation powers; and can receive and investigate complaints about the way in which organisations respond to reportable allegations or convictions.

The Reportable Conduct Process



Reportable allegations and convictions

Organisations within the scope of the Scheme are required to notify the Ombudsman within seven working days of becoming aware of:

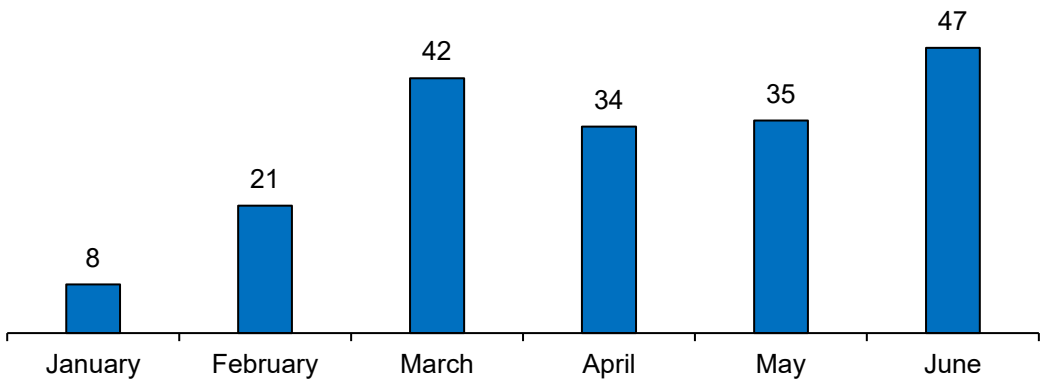
- a **reportable allegation** (namely, matters that include "any information that leads a person to form the belief on reasonable grounds that an employee of a relevant entity has engaged in reportable conduct or conduct that may involve reportable conduct"); and
- a **reportable conviction** (that are matters involving "a conviction, whether before, on or after commencement day, for an offence under a law of this State, another State, a Territory or the Commonwealth that is an offence referred to in section 19G(1)(a) [a sexual offence] or (d) [an offence prescribed by the regulations for the purposes of this paragraph]."

During 2022-23, the Office received 194 notifications of reportable allegations under the Scheme.

Notifications of reportable allegations

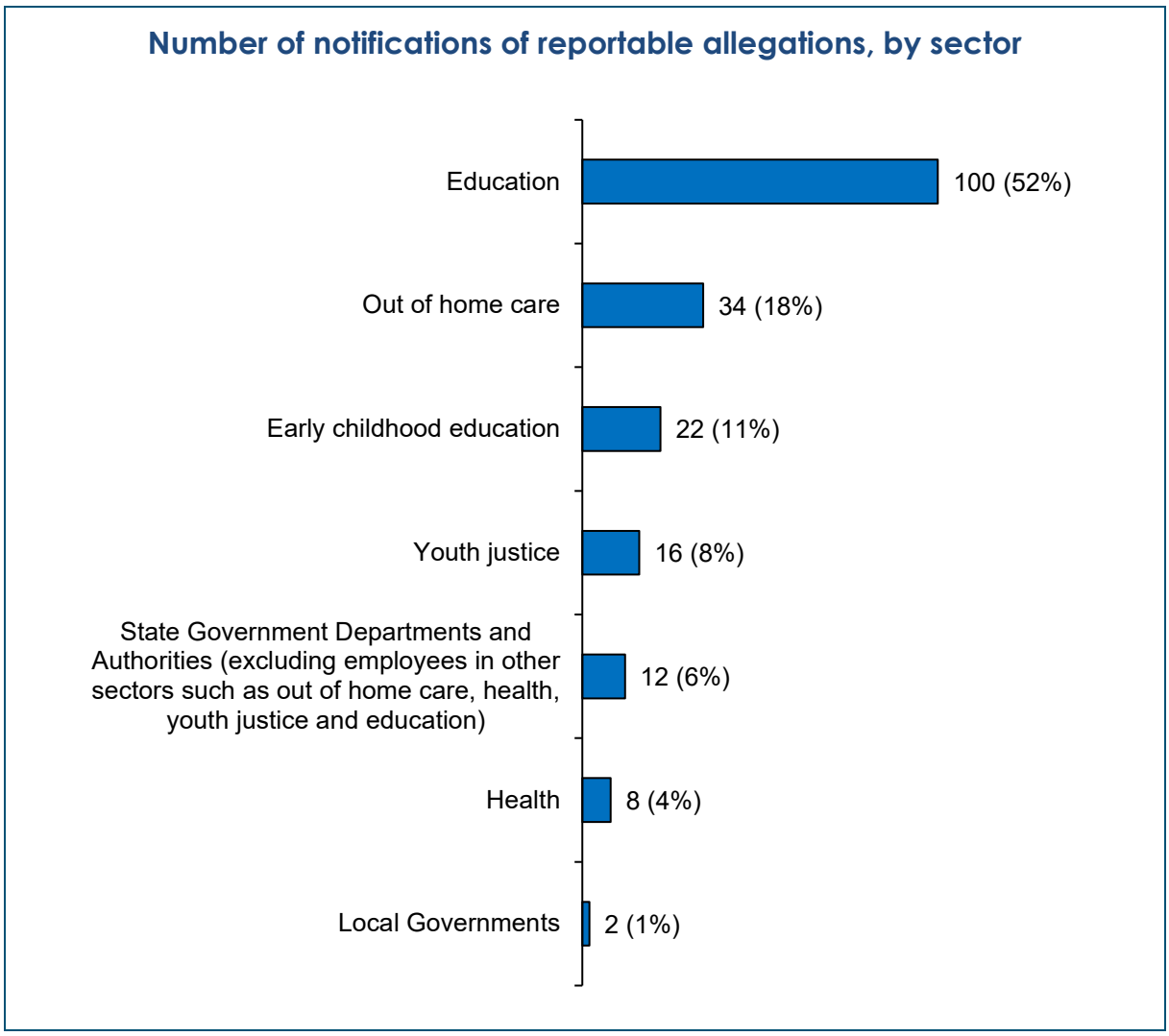
Since the commencement of the Scheme on 1 January 2023, the Office has received 194 notifications of reportable allegations. The Office did not receive any notifications of reportable convictions from 1 January 2023 to 30 June 2023.

Number of notifications of reportable allegations, by month received



Notifications by sector

In 2022-23, the education, out of home care and early childhood education sectors reported most frequently to the Office (52 per cent, 18 per cent and 11 per cent, respectively), as shown in the chart below:



From 1 January 2024, the Scheme will be expanded to include the following organisations:

- Accommodation and residential services;
- Religious institutions; and
- Disability services.

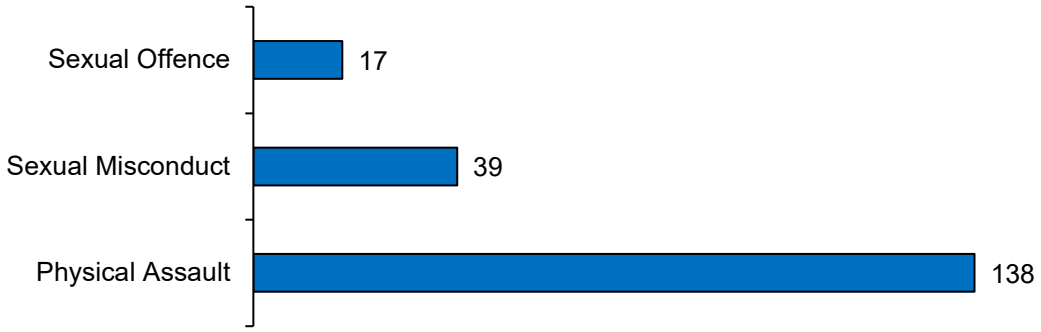
Reportable conduct notifications by reportable allegation type

Under the Act, there are three types of allegations of reportable conduct that must be reported to the Ombudsman:

- Sexual offences (against, with or in the presence of, a child);
- Sexual misconduct (against, with or in the presence of, a child); and
- Physical assault (against, with or in the presence of, a child).

The majority of notifications received in 2022-23 involved allegations of physical assault (128 notifications, 71 per cent), as shown in the chart below:

Number of reportable conduct notifications by type of reportable conduct alleged



There is a phased commencement of the Scheme over two years. From 1 January 2024, reportable conduct will also include:

- Significant neglect of a child; and
- Any behaviour that causes significant emotional or psychological harm to a child.

Enquiries

The Office has a dedicated reportable conduct enquiries line and email address as an important part of its function to provide information and education about the Scheme. During 2022-23, the Office received 126 enquiries.

Findings and outcomes of entity investigations of reportable conduct

Section 19Z of the Act requires organisations to provide the Office with a written report of the outcomes of all reportable conduct investigations, including the actions taken, as set out below:

(1) The head of a relevant entity must, as soon as practicable after the end of an investigation under section 19W(1), give the Commissioner –

(a) a written report setting out –

(i) the findings of the investigation and the reasons for those findings; and

(ii) any submissions made by the employee under section 19X; and

(iii) any disciplinary or other action taken, or proposed to be taken in relation to the employee as a result of the findings of the investigation; and

(iv) if the entity does not propose to take any disciplinary or other action in relation to the employee – the reasons why no action is to be taken; and

(v) any action taken, or proposed to be taken, as a result of the findings of the investigation, to improve the identification or prevention of reportable conduct, or the reporting, notification or investigation of reportable allegations and reportable convictions, involving employees of the relevant entity.

and

(b) any other information that the head of the relevant entity considers relevant to the report.

(2) After receiving the report and other information, the Commissioner may, by written notice given to the head of the relevant entity, request any additional information specified in the notice that the Commissioner considers relevant to determine whether –

(a) the reportable allegation or reportable conviction was properly investigated; and

(b) appropriate action was taken as a result of the investigation.

(3) The head of a relevant entity must comply with a request under subsection (2).

(4) It is an offence for the head of a relevant entity to fail, without reasonable excuse, to comply with subsection (1) or (3).

Penalty for this subsection: a fine of $5 000.

The Office assesses each investigation report against the requirements of the Act and may seek further information regarding an entity's response to a reportable allegation. A relevant entity may also be provided with advice or education to assist it in improving its systems for preventing, identifying and responding to reportable conduct.

Of the investigations undertaken by organisations, and monitored by the Office, in 2022-23, all were found to be compliant with the requirements of the Act. In 2022-23, the Office received 20 investigation reports.

Exempt investigations

The Ombudsman may exempt the head of a relevant entity from commencing or continuing an investigation in certain circumstances, including when:

- the matter is already being dealt with or investigated by another appropriate person or body; or
- the head of the relevant entity has made a request for the exemption in a notice under section 19Y of the Act.

During 2022-23, the Office received 17 requests from a relevant entity requesting an exemption from continuing an investigation:

- Two requests were later withdrawn by the relevant entity;
- Ten exemptions were granted; and
- Five requests for an exemption were under consideration on 30 June 2023.

Exempt organisations

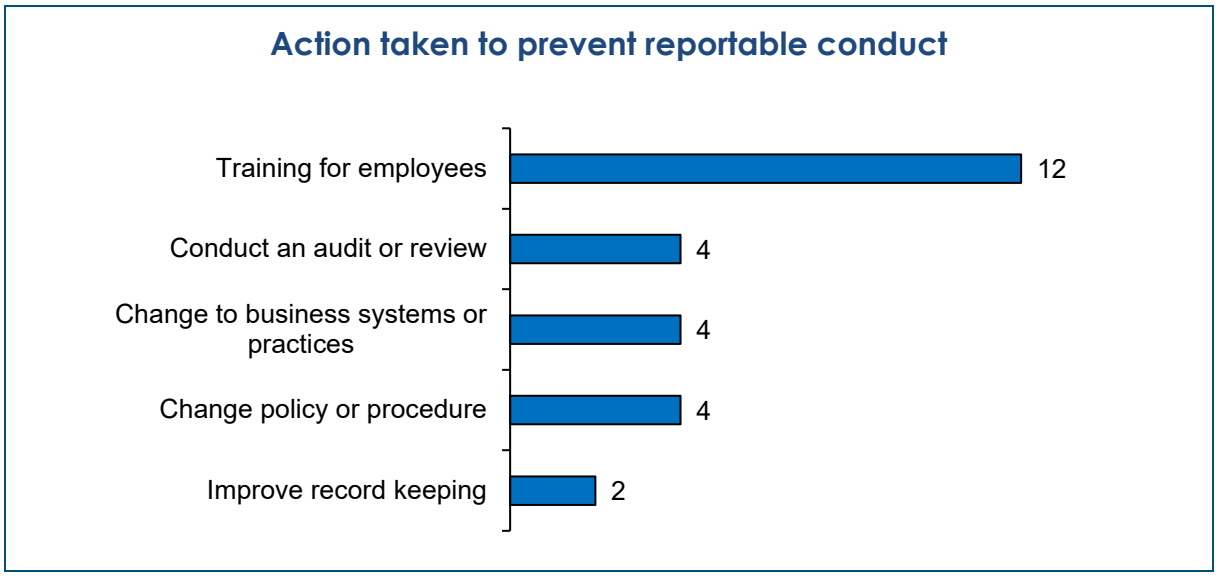
The Ombudsman may also exempt an organisation from the Scheme, by written notice given pursuant to section 19O of the Act.

During 2022-23, no organisations were exempted from the Scheme.

Action taken to prevent reportable conduct

During 2022-23, a total of 26 actions were taken by organisations to prevent reportable conduct at the conclusion of a reportable conduct investigation.

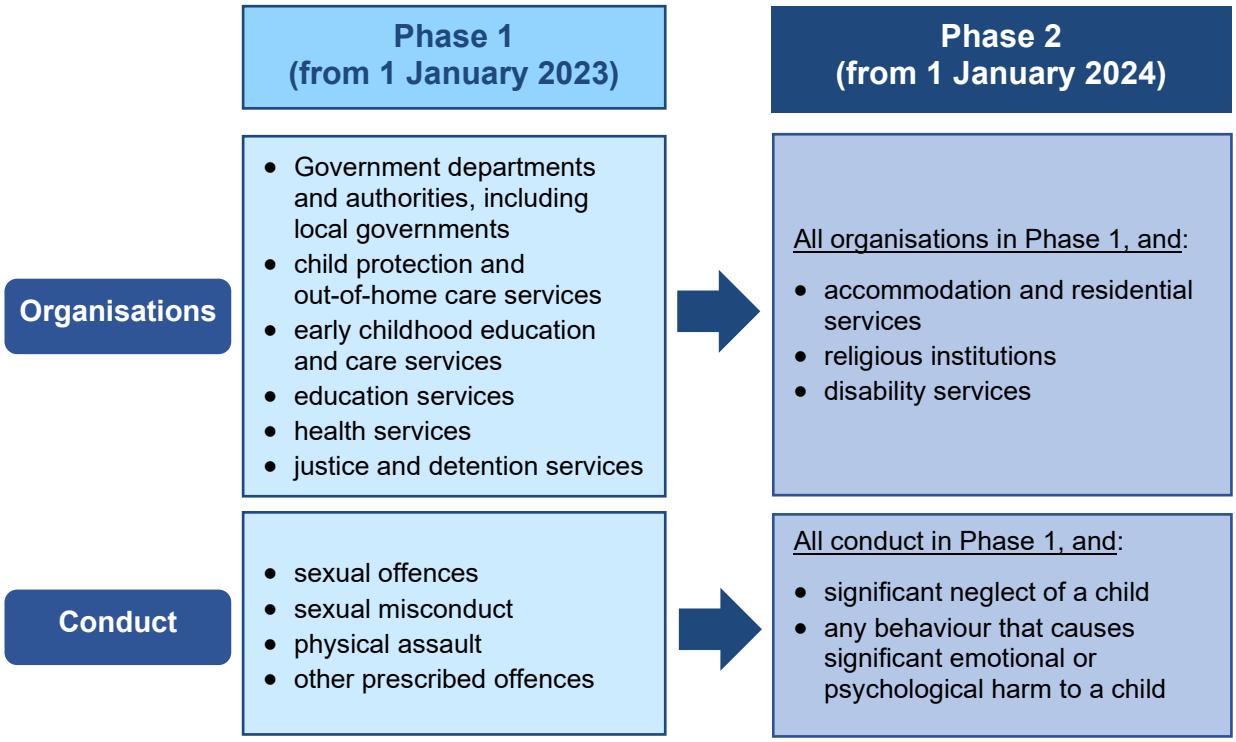
The chart below provides a summary of the types of actions taken to improve reportable conduct systems within organisations:



The Office collects a range of additional information about the improvement actions undertaken by organisations at all stages of the reportable conduct process, including actions taken prior to Ombudsman involvement and actions taken during the identification and notification of a reportable conduct matter regarding the safety of children.

Phased development of the Reportable Conduct Scheme

The Scheme commenced on 1 January 2023. There is a phased commencement of the Scheme over two years to assist organisations to prepare for the new requirements. The diagram below sets out how the phased commencement will work.



The types of organisations covered by the Reportable Conduct Scheme

The Scheme will only apply to organisations that exercise care, supervision or authority over children. The types of organisations covered by the Scheme include:

Phase 1 (from 1 January 2023):

- Western Australian government departments and authorities, including local governments;
- Child protection and out-of-home-care services:
  - Providers of approved foster carers and kinships carers;
  - Providers of residential care and family group homes;
- Early childhood education and care services:
  - Providers of approved education and care services and child care services;
  - Providers of an approved family day care service;
- Education services:
  - Government and non-government schools;
  - TAFE colleges;
  - Registered training organisations;
  - Universities;
- Health services:
  - Public health service providers;
  - Licensed private hospital service providers;
  - Mental health service providers that have inpatient beds for children;
  - Drug and alcohol treatment service providers that have inpatient beds for children;
  - Ambulance services;
- Justice and detention services:
  - A provider of a juvenile detention centre; and
  - A provider of community justice services funded by the Department of Justice.

Phase 2 (from 1 January 2024):

- Accommodation and residential services:
  - Providers of a homelessness service that provides overnight beds specifically for children as part of its primary activities and is funded by the Department of Communities;
  - Providers of boarding facilities for students who are children;
  - Organisations that provide overnight camps for children as part of its primary activity;
  - A provider of any other accommodation or respite services for children;
- Religious bodies; and
- Disability service providers.

Education and guidance

The Office undertakes its function of providing education and guidance through:

- Our dedicated enquiries line and reportable conduct email address;
- Providing information to organisations during reportable conduct investigations;
- Delivering in-person and online presentations to organisations; and
- Publishing a range of online guidance and support materials on our website.

During 2022-23, the Office worked closely and cooperatively with stakeholders in key sectors and organisations included in the Scheme to provide education and guidance to assist in building their capacity to meet their reporting obligations and comply with the Scheme. This included:

- Attending meetings with organisations and delivering workshops on the Scheme;
- Developing tailored guidance and support materials and education programs for each sector, in collaboration with peak bodies for the sector; and
- Providing information to organisations to assist them in their handling of individual investigations.

During 2022-23, the Office held a range of information sessions and workshops for organisations covered by the Scheme and other stakeholders. This included webinars for eight key sectors in November 2022, and a further 30 stakeholder presentations and meetings in the six months after the Scheme commenced on 1 January 2023.

In addition, the Office regularly liaised with a range of bodies in relation to the Scheme, including:

- The Department of Communities;
- The Department of Education;
- The Department of Health;
- The Department of Justice;
- WA Police Force; and
- The interjurisdictional forum for Reportable Conduct Schemes comprising the Office and the NSW Children's Guardian, the Victorian Commissioner for Children and Young People and the ACT Ombudsman.

Charitable Trusts

On 21 November 2022, the Ombudsman commenced an important new function as the Western Australian Charitable Trusts Commission (**WACTC**) following the commencement of the *Charitable Trusts Act 2022* (**CT Act**).

Complaints may be made directly to the Ombudsman as the WACTC or matters may be referred to the Ombudsman by the Attorney General for investigation.

Charitable trusts play a significant role in the Western Australian Aboriginal community as they are utilised to hold mining royalties and native title settlement funds. The Office has significant expertise in investigations involving Aboriginal communities and complainants to support this new function.

Information regarding reporting

The annual reporting of the work of the Office as the WACTC will be developed over future annual reports. This will include deidentified case studies and further information and systemic analysis over time arising from being the WACTC.

Role of the Ombudsman as the Western Australian Charitable Trusts Commission

The role of the Ombudsman, as WACTC, is set out in Section 30 of the CT Act, and is to:

(a) conduct investigations, including audits of the accounts of charitable trusts under investigation;
(b) make an investigator's report on each investigation; and
(c) make recommendations to the trustees of charitable trusts in respect of matters arising out of investigations.

The Ombudsman is afforded specific powers under the CT Act as well as being able to rely on existing powers under the *Parliamentary Commissioner Act 1971* which includes the powers, rights and privileges of a Royal Commission.

The CT Act also provides the Ombudsman with specific investigative powers, including the power to issue a notice requiring a person to provide a document or information relating to a charitable trust or concerning any person involved in the administration of a charitable trust.

The Ombudsman must prepare a report on an investigation and that report must be provided to the Attorney General. The report may be accompanied by a notice for a trustee to take reasonably necessary action(s) in a specified timeframe. Failure to comply with a notice and take those actions is grounds for the removal of the trustee.

Complaints and enquiries received

From 21 November 2022 to 30 June 2023, the Office received:

- Seven enquiries about Charitable Trusts (three of which progressed to a complaint); and
- Six complaints about Charitable Trusts.

Of the six complaints received, five were closed during 2022-23:

- Four matters were out of the Ombudsman's jurisdiction; and
- One matter was resolved by the Office.

If a complaint is outside the Ombudsman's jurisdiction, where possible, the Office provides the complainant with contact details for other State and Commonwealth regulators who may be able to assist with their complaint.

Collaboration and Access to Services

Engagement with key stakeholders is essential to the Office's achievement of the most efficient and effective outcomes. The Office does this through:

- Working collaboratively with other integrity and accountability bodies – locally, nationally and internationally – to encourage best practice, efficiency and leadership;
- Ensuring ongoing accountability to Parliament as well as accessibility to its services for public authorities and the community; and
- Developing, maintaining and supporting relationships with public authorities and community groups.

Working Collaboratively

The Office works collaboratively with local, national and international integrity and accountability bodies to promote best practice, efficiency and leadership. Working collaboratively also provides an opportunity for the Office to benchmark its performance and stakeholder communication activities against other similar agencies, and to identify areas for improvement through the experiences of others.

Information sharing with Ombudsmen from other jurisdictions

Background:

Where appropriate, the Office shares information and insights about its work with Ombudsmen from other jurisdictions, as well as with other accountability and integrity bodies.

The Office's involvement:

The Office exchanged information with a number of Parliamentary Ombudsmen and industry-based Ombudsmen during the year.

Australia and New Zealand Ombudsman Association

Members: Parliamentary and industry-based Ombudsmen from Australia and New Zealand.

Background:

The Australia and New Zealand Ombudsman Association (**ANZOA**) is the peak body for Parliamentary and industry-based Ombudsmen from Australia and New Zealand.

The Office's involvement:

The Office is a member of ANZOA. The Office periodically provides general updates on its activities and also has nominated representatives who participate in interest groups in the areas of Indigenous engagement, systemic issues and policy influence, people and development, data and analytics, and public relations and communications.

Providing Access to the Community

Communicating with complainants

The Office provides a range of information and services to assist specific groups, and the public more generally, to understand the role of the Ombudsman and the complaint process. Many people find the Office's enquiry service and drop-in clinics held during regional visits assist them to make their complaint. Other initiatives in 2022-23 include:

- Regular updating of the Ombudsman's publications and website to provide easy access to information for people wishing to make a complaint and those undertaking the complaint process;
- Ongoing promotion of the role of the Office and the type of complaints the Office handles through presentations and participating in events in the community; and
- The Office's Youth Awareness and Accessibility Program and Prison Program.

Access to the Ombudsman's services

The Office continues to implement a number of strategies to ensure its complaint services are accessible to all Western Australians. These include access through online facilities as well as more traditional approaches by letter and through visits to the Office. The Office also holds drop-in clinics and engages with community groups, particularly through the Regional Awareness and Accessibility Program. Initiatives to make services accessible include:

- Access to the Office through a Freecall number, which is free from landline phones;
- Access to the Office through email and online services. The importance of email and online access is demonstrated by their use this year in 85% of all complaints received (44% by email and 41% through the website complaint form);
- Information on how to make a complaint to the Ombudsman is available in 17 languages in addition to English and features on the homepage of the Ombudsman's website. People may also contact the Office with the assistance of an interpreter by using the Translating and Interpreting Service;
- The Office's accommodation, building and facilities provide access for people with disability, including lifts that accommodate wheelchairs and feature braille on the access buttons and people with hearing and speech impairments can contact the Office using the National Relay Service;
- The Office's Regional Awareness and Accessibility Program and Youth Awareness and Accessibility Program target awareness and accessibility for regional and Aboriginal Western Australians as well as children and young people;
- The Office attends events to raise community awareness of, and access to, its services, such as:
    - The Financial Counsellors' Association of WA Conference marketplace in November 2022;
    - The Wagin Woolorama Agricultural Show in March 2023; and
    - The Multicultural Communities Council WA mini-expo as part of the Refugee Week event, *Finding Freedom: Refugee Mental Health and Inclusion Symposium* in June 2023.
- The Office's visits to adult prisons and the juvenile detention centre provide an opportunity for adult prisoners and juvenile detainees to meet with representatives of the Office and lodge complaints in person.

The Office held an information stall at the Multicultural Communities Council of WA mini-expo in June 2023.

Ombudsman website

The Ombudsman's website provides a wide range of information and resources for:

- Members of the public on the complaint handling services provided by the Office as well as links to other complaint bodies for issues outside the Ombudsman's jurisdiction;
- Public authorities on decision making, complaint handling and conducting investigations;
- Organisations that work with children on the Reportable Conduct Scheme;
- Children and young people as well as information for non-government organisations and government agencies that assist children and young people, including downloadable print material tailored for children and young people. The youth pages can be accessed at www.ombudsman.wa.gov.au/youth;
- Access to the Ombudsman's reports such as *Investigation into family and domestic violence and suicide*, *A report on giving effect to the recommendations arising from the Investigation into the handling of complaints by the Legal Services and Complaints Committee* and *A report on giving effect to the recommendations arising from An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley*;
- The latest news about events and collaborative initiatives such as the Regional Awareness and Accessibility Program; and
- Links to other key functions undertaken by the Office such as the Energy and Water Ombudsman website and other related bodies including other Ombudsmen and other Western Australian accountability agencies.

The website continues to be a valuable resource for the community and public sector as shown by the increased use of the website this year. In 2022-23:

- The total number of visits to the website was 106,863;
- The top two most visited pages (besides the homepage and the Contact Us page) on the site were *How to make a complaint* and *What you can complain about*; and
- The Office's *Effective Handling of Complaints Made to Your Organisation Guidelines* and *Procedural Fairness Guidelines* were the two most viewed documents.

The website content and functionality are continually reviewed and improved to ensure there is maximum accessibility to all members of the diverse Western Australian community. The site provides information in a wide range of community languages and is accessible to people with disability.

Regional Awareness and Accessibility Program

The Office continued the Regional Awareness and Accessibility Program (**the Program**) during 2022-23. Regional visits were conducted to Newman, Tom Price, Paraburdoo and the Jigalong community in the East Pilbara Region in November 2022 and Karratha, Roebourne and Port Hedland in the West Pilbara Region in May 2023. The visits include activities such as:

- Drop-in clinics, which provided an opportunity for members of the local community to raise their concerns face-to-face with the staff of the Office;
- Information sessions for the Aboriginal community, Elders and service providers, which provided an opportunity for Aboriginal communities to discuss government service delivery and where the Office may be able to assist;
- Liaison with community, advocacy and consumer organisations to provide information about our role;
- Liaison with public authorities, including a workshop on *Effective Complaint Handling and Good Decision Making* in Karratha in May 2023; and
- Liaison with organisations that work with children to provide information about the Reportable Conduct Scheme, including an *Introduction to the Reportable Conduct Scheme* information session in Karratha in May 2023.

The Program is an important way for the Office to raise awareness of, access to, and use of, its services for regional and Aboriginal Western Australians. In 2022-23, the visits were coordinated with the Western Australian Energy and Water Ombudsman, the Health and Disability Services Complaints Office, the Equal Opportunity Commission, the Commonwealth Ombudsman, the Office of the Information Commissioner (WA), and the Aboriginal Legal Service.

The Office also:

- Hosted a webinar, *Ombudsman Complaint Resolution Webinar for Community Sector Organisations* in July 2022. The webinar was delivered in collaboration with the Energy and Water Ombudsman, Commonwealth Ombudsman, Telecommunications Industry Ombudsman, Australian Financial Complaints Authority, Health and Disability Services Complaints Office and the Equal Opportunity Commission; and
- Held an information stall at the Wagin Woolorama Agricultural Show in March 2023, in collaboration with the Energy and Water Ombudsman and Health and Disability Services Complaints Office.

The Office held an information stall at the Wagin Woolorama Agricultural Show in March 2023, in collaboration with the Energy and Water Ombudsman and Health and Disability Services Complaints Office.

The Program enables the Office to:

- Deliver key services directly to regional communities, particularly through drop-in clinics and information sessions;
- Increase awareness and accessibility among regional and Aboriginal Western Australians (who were historically under-represented in complaints to the Office); and
- Deliver key messages about the Office's work and services.

The Program also provides a valuable opportunity for staff to strengthen their understanding of the issues affecting people in regional and Aboriginal communities.

Attendees at the Information session for the Aboriginal community, Elders and service providers in Newman, November 2022, with representatives from the Office, the Commonwealth Ombudsman, Equal Opportunity Commission, Health and Disability Services Complaints Office and Office of the Information Commissioner (WA).

The Office held a drop-in clinic at the Tom Price Community Resource Centre in November 2022.

Aboriginal engagement

In 2016, the Office recruited a Principal Aboriginal Consultant, and in 2016-17, the Office developed the *Aboriginal Action Plan*, a comprehensive whole-of-office plan to address the significant disadvantage faced by Aboriginal people in Western Australia. The plan contributes to an overall goal of developing an organisation that is welcoming and culturally safe for Aboriginal people and meets the unique needs of the Aboriginal community it serves.

In 2018, the Office established two additional Aboriginal positions and in 2021-22, created a critical new executive position, Assistant Ombudsman Aboriginal Engagement and Collaboration, which was filled by Laurence Riley in August 2022. At 30 June 2023, the Office had three staff (3.9% of the Offices total FTE) identifying as Aboriginal in the Aboriginal Engagement and Collaboration Branch.

The Office also engaged an Aboriginal artist in 2018 to produce an artwork for the Office. The artwork is featured on the cover of this report and has been used as a theme for new publications.

The Aboriginal Engagement and Collaboration Branch members attended events and meetings with government and non-government service providers to provide an opportunity to raise issues affecting the Aboriginal community and to raise awareness of the Office's role.

The Office also continued its engagement with the wider Aboriginal community through:

- Aboriginal community information sessions as part of its Regional Awareness and Accessibility Program;
- Visits to remote Aboriginal communities during regional visits, including a visit to Jigalong community in the East Pilbara Region in November 2022; and
- Seeking consultation with Aboriginal people with particular expertise for major investigations, reports and other functions of the Office. See further details in the Own Motion Investigations, Monitoring and Improvement section.

The Aboriginal staff also coordinated cultural awareness information and events throughout the year, including training on *Aboriginal Cultural Awareness* for staff of the Office, and provided information to staff about culturally important dates and events being held in the community.

Youth Awareness and Accessibility Program

The Office has a dedicated youth space on the Ombudsman Western Australia website with information about the Office specifically tailored for children and young people, as well as information for non-government organisations and government agencies that assist children and young people.

The website also has:

- A suite of promotional materials targeted at, and tailored for, children and young people; and
- A poster for children and young people translated into 15 community languages.

In 2022-23, these materials along with a colouring-in version of the poster were distributed to the community and organisations during the Office's Regional Awareness and Accessibility Program.

The Ombudsman has also continued visits to the Banksia Hill Detention Centre and engagement with community sector youth organisations in regional Western Australia under the Ombudsman's Regional Awareness and Accessibility Program.

The children and young people section of the Ombudsman's website can be found at www.ombudsman.wa.gov.au/youth.

Prison Program

The Office continued the Prison Program during 2022-23. Eight visits were made to prisons and the juvenile detention centre to raise awareness of the role of the Ombudsman and enhance accessibility to the Office for adult prisoners and juvenile detainees in Western Australia.

Speeches and Presentations

Staff delivered speeches and presentations throughout the year at local, national and international conferences and events.

- *Ombudsman Complaint Resolution Webinar for Community Sector Organisations* by the Deputy Ombudsman, Principal Aboriginal Consultant and Principal Project Officer in July 2022, in collaboration with the Energy and Water Ombudsman, Commonwealth Ombudsman, Telecommunications Industry Ombudsman, Health and Disability Services Complaints Office and Equal Opportunity Commission;
- *Ombudsman Western Australia and Energy and Water Ombudsman*, presented by the Principal Project Officer in collaboration with the Health and Disability Services Complaints Office to clients of the Lorikeet Centre in October 2022;
- *Keeping Accountability Agencies Accountable* presented by the Principal Analyst and Principal Project Officer to University of Western Australia students as part of the Government Accountability Law and Practice Unit in January 2023;
- *The Ombudsman: Traditional and Emerging Functions to Investigate and Monitor Administrative Actions* presented by the Principal Assistant Ombudsman to the State Solicitor's Office whole-of-government Continuing Professional Development Program session for government lawyers in February 2023;
- *Ombudsman Western Australia and Energy and Water Ombudsman*, presented by the Assistant Ombudsman Energy and Water and the Principal Project Officer to senior staff of the Small Business Development Corporation in May 2023;
- *Can I refer you… The Western Australian Ombudsman* presented by the Principal Project Officer to, and in collaboration with, other complaint handling organisations in May 2023; and
- *Child Death Reviews and Family and Domestic Violence Fatalities*, presented by the Senior Assistant Ombudsman Reviews to the Department of Justice's Youth Justice Service Team Leader Conference in June 2023.

The Ombudsman's speeches and presentations are detailed in The Office of the President of the International Ombudsman Institute and Ombudsman section of this report and the Ombudsman and IOI President's Speeches and Engagements page of the website. Video recorded and written speeches by the Ombudsman are available on the Speeches by the Ombudsman page of the website.

Liaison with Public Authorities

Liaison relating to complaint resolution

The Office liaised with a range of bodies in relation to complaint resolution in 2022-23, including:

- The Department of Communities;
- The Department of Education;
- Various prisons; and
- The Corruption and Crime Commission.

Liaison relating to reviews

The Office undertook a range of liaison activities in relation to its reviews of child deaths and family and domestic violence fatalities.

See further details in the Child Death Review section and the Family and Domestic Violence Fatality Review section.

Liaison relating to the Reportable Conduct Scheme

During 2022-23, the Office held a range of information sessions and workshops for organisations covered by the Reportable Conduct Scheme and other stakeholders. This included webinars for eight key sectors in November 2022, and a further 30 stakeholder presentations and meetings in the six months after the Reportable Conduct Scheme commenced on 1 January 2023.

In addition, the Office regularly liaised with a range of bodies in relation to the Reportable Conduct Scheme.

See further details in the Reportable Conduct Scheme section.

Liaison relating to own motion investigations, inspection and monitoring functions

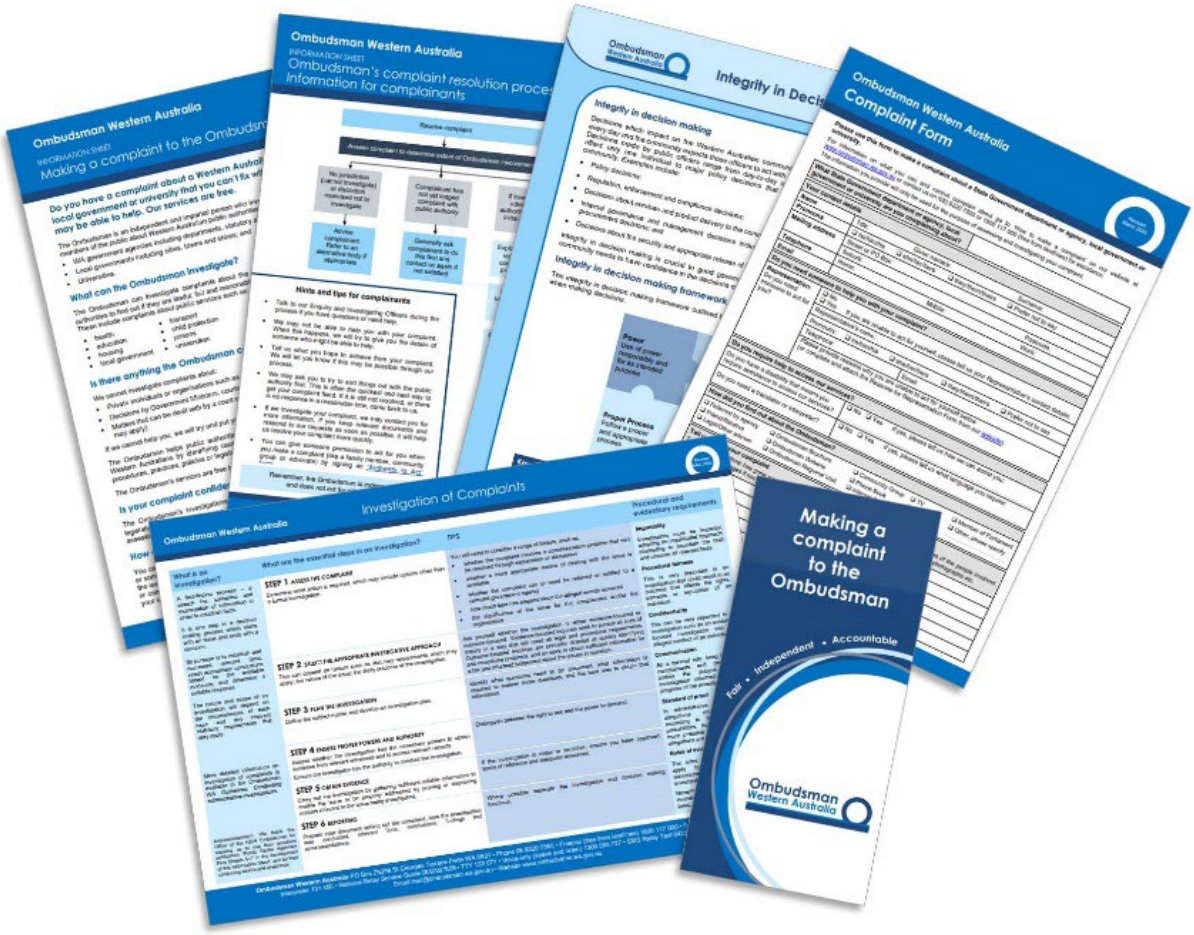
The Office undertook a range of liaison activities in relation to its own motion investigations, inspection and monitoring functions.

See further details in the Own Motion Investigations, Monitoring and Improvement section.

Publications

The Office has a comprehensive range of publications about the role of the Ombudsman, which are available on the Ombudsman's website.

For a full listing of the Office's publications, see Appendix 3.


Ombudsman Western Australia
Making a complaint to the Ombudsman
Ombudsman Western Australia
Ombudsman's complaint resolution process
Information for complainants
Integrity in Decision Making
Ombudsman Western Australia
Complaint Form
Ombudsman Western Australia
Investigation of Complaints
Making a complaint to the Ombudsman
Fair • Independent • Accountable
Ombudsman Western Australia

The Office of the President of the International Ombudsman Institute and Ombudsman

International Ombudsman Institute

The International Ombudsman Institute (**IOI**), established in 1978, is the only global organisation for the cooperation of more than 205 independent Ombudsman institutions from more than 100 countries worldwide. The IOI is organised into six regional chapters: Africa; Asia; Australasian and Pacific; Europe; the Caribbean and Latin America and North America.

In May 2021, the Ombudsman commenced a three-year term as President of the IOI at the Closing Ceremony of the 12th quadrennial World Conference of the IOI held (virtually) in Dublin.

In the 45-year history of the IOI, the Ombudsman is the only Australian that has been elected President. It was also the first time a President was elected by a vote open to all members of the IOI. Historically, the President was elected by a majority vote of the World Board of the IOI.

The IOI is governed by a World Board, of which the Ombudsman has served as the President since May 2021, following a term as the Second Vice-President between 2016 and 2021. Before this, the Ombudsman served as Treasurer of the IOI from 2014 to 2016, and President of the Australasian and Pacific Ombudsman Region (**APOR**) of the IOI from 2012 to 2014.

2022-23 initiatives

IOI President is guest of honour at international human rights conference in Ukraine

The IOI President and IOI Vice President Europe and Parliamentary and Health Service Ombudsman of the United Kingdom, Rob Behrens CBE (**Ombudsman Behrens**), attended the International Conference "Human Rights in Dark Hours" in Ukraine. Due to the fact that Ukraine is under ongoing missile and drone attack from the Russian Federation, the conference was held in one of the deepest subway stations in the world. The Conference commenced with a poignant candlelight vigil for those Ukrainians who have made the ultimate sacrifice for democracy, freedom, the rule of law and the sovereign nation of Ukraine.

Left to right: Dmytro Lubinets, Ukrainian Parliament Commissioner for Human Rights; Chris Field PSM, IOI President; Andrii Borysovych Yermak, Head of the Office of the President of Ukraine; and Volodymyr Zelensky, President of Ukraine.

Time Person of the Year, President Zelensky, provided a powerful opening speech. In his speech, President Zelensky specifically noted the visit to Ukraine by the IOI: "I am glad that Chris Field is present among us today - it's my pleasure, good afternoon - President of the International Ombudsman Institute, a representative of a system whose potential can provide much more for the protection of human rights for Ukraine."

The IOI President followed President Zelensky in addressing the conference. An entire session of the conference was dedicated to Ombudsman Behrens undertaking a Q & A session with the Ukrainian Parliament Commissioner for Human Rights, Dmytro Lubinets. The IOI President also undertook an international press conference.

Chris Field PSM, IOI President, addresses an international press conference at the International Conferenace “Human Rights in Dark Hours” in Ukraine.

IOI President meets Chairman and Speaker of the Verkhovna Rada, Ruslan Stefanchuk in Ukraine

The IOI President and Ombudsman Behrens were honoured to meet the Chairman and Speaker of the Verkhovna Rada, Ruslan Stefanchuk in Ukraine. The Chairman and Speaker issued a press statement following the meeting noting that, “This is an example of professionalism and courage for the leaders of the world human rights institutions. You demonstrate your commitment to the ideals of human rights and freedom not in words, but in deeds,” and that “He expressed personal gratitude to the President Chris Field for his contribution to the exclusion of the Ombudsman of the Russian Federation Tatiana Moskalkova from the Institute”, calling it “an act of justice”.

Left to right: Ombudsman Behrens; Ruslan Stefanchuk, Chairman and Speaker of the Verkhovna Rada; Chris Field PSM, IOI President; and Dmytro Lubinets, Ukrainian Parliament Commissioner for Human Rights.

IOI President visits Kyiv, Ukraine

The IOI President and Ombudsman Behrens, visited the bunker used by the staff of the Ukrainian Parliament Commissioner for Human Rights during Russian Federation missile attacks. This was followed by a formal exchange with the Commissioner and his senior staff, before attending a meeting of the Coordination Council of the Ombudsman of Ukraine, a senior advisory council of civil society human rights experts. Both the IOI President and Ombudsman Behrens had the privilege of addressing the Council.

Captured Russian Federation military equipment in Kyiv.

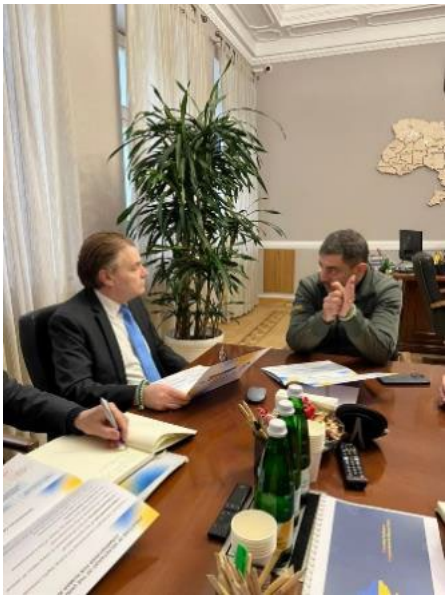
The IOI President and Ombudsman Behrens visited places of destruction in Kyiv. One particularly tragic moment was seeing an operational power station that was intended to be destroyed by a Russian missile. Instead, this missile destroyed a residential apartment building on the other side of the road with the loss of lives of Ukrainian civilians.

The visit then included inspecting captured Russian Federation military equipment, prior to paying respect to those soldiers who have given their lives for their country. The day finished by visiting a 'Point of Invincibility', an 'inflatable' building that has power, tea, coffee, water and beds for Ukrainian citizens, and particularly as the temperature starts to fall to -10 or less, these buildings are heated.

Loss of life and destruction in Kyiv.

A memorial to fallen Ukrainian soldiers.

A point of invincibility in Kyiv.



Chris Field PSM, IOI President, meets with Commissioner Lubinets.

IOI President visits Irpin, Ukraine

The IOI President and Ombudsman Behrens undertook a visit to the city of Irpin in Ukraine. Only twenty kilometres from Kyiv, the Russian Federation invaded Irpin, with Kyiv its next target. What followed was a battle that initially saw hundreds of civilians killed and a huge number of internally displaced persons and refugees. The invasion wrought mass destruction with 70% of this thriving city destroyed. President Zelensky named Irpin the 'Hero City of Ukraine'. The IOI President and Ombudsman Behrens spoke at length to just one of those heroes.

Left to right: Dmytro Lubinets, Ukrainian Parliament Commissioner for Human Rights; Negresha Dmytro Mykhailovych, Deputy Mayor of Irpin; Chris Field PSM, IOI President; and Ombudsman Behrens.

Destruction in Irpin, Ukraine.

Destruction in Irpin, Ukraine.

A memorial in Irpin, Ukraine.

Destruction in Irpin, Ukraine.

IOI President meets with Australian Ambassador to Poland, His Excellency Mr Lloyd Brodrick, and Australian Ambassador to Ukraine, His Excellency Mr Bruce Edwards, during visit to Poland

Immediately prior to his visit to Ukraine, the IOI President visited Poland. The IOI President met with Australian Ambassador to Poland, His Excellency Mr Lloyd Brodrick, and Australian Ambassador to Ukraine, His Excellency Mr Bruce Edwards. The Ambassadors and the IOI President were able to discuss a large number of matters relevant to to the valued relationship between Poland and Australia as well as the current situation in Ukraine.

Left to right: His Excellency Mr. Lloyd Brodrick, Australian Ambassador to Poland; Chris Field PSM, IOI President; and His Excellency Mr. Bruce Edwards, Australian Ambassador to Ukraine.

IOI President meets with His Excellency Mr Vasyl Zvarych, Ambassador of Ukraine to Poland during visit to Poland

The IOI President, accompanied by His Excellency Mr Bruce Edwards, Australian Ambassador to Ukraine, met with His Excellency Mr Vasyl Zvarych, Ambassador of Ukraine to Poland, during his official visit to Poland. During the meeting it was indicated to His Excellency that the IOI stands resolutely and unambiguously with the people of Ukraine.

Left to right: His Excellency Mr Vasyl Zvarych; Ambassador of Ukraine to Poland; Chris Field PSM, IOI President; and His Excellency Mr Bruce Edwards, Australian Ambassador to Ukraine.

IOI President meets with the Commissioner for Human Rights of Poland, Professor Marcin Wiącek, during official visit to Poland

The IOI President met with Professor Marcin Wiącek, Commissioner for Human Rights of Poland, during his visit to Poland. At this meeting, the IOI President was delighted to be joined by Ombudsman Behrens and His Excellency Mr Lloyd Brodrick, Australian Ambassador to Poland.

Left to right: Chris Field PSM, IOI President; Professor Marcin Wiącek, Commissioner for Human Rights of Poland; Rob Behrens CBE, IOI Vice President Europe and Parliamentary and Health Service Ombudsman of the United Kingdom.

IOI President attends border crossing points at the Hungarian-Romanian and Hungarian-Ukrainian borders during visit to Hungary

The IOI President attended border crossing points at the Hungarian-Romanian and Hungarian-Ukrainian borders during his visit to Hungary which followed an invitation from Dr Ákos Kozma, Commissioner for Fundamental Rights of Hungary. Over a period of two days, the IOI President was privileged to meet local Mayors, doctors, nurses, Red Cross staff, and border crossing officers, all of whom have played a vital role in ensuring the well-being and safe passage of more than one million refugees escaping the Russian Federation's brutal and unlawful invasion of Ukraine. The visit included the Csengersima-Petea crossing point at the Hungarian-Romanian border and the Záhony, Beregsurány and Lónya crossing points at the Hungarian-Ukrainian border.

Left to right: Dr Ákos Kozma, Commissioner for Fundamental Rights of Hungary; and Chris Field PSM, IOI President.

Chris Field PSM, IOI President, speaking with an official at a crossing point at the Hungarian border.

Chris Field PSM, IOI President visits field office of the Commission of Fundamental Rights of Hungary.

Left to right: Chris Field PSM, IOI President; and Dr Ákos Kozma, Commissioner for Fundamental Rights of Hungary at Hungary and Ukraine border.

Chris Field PSM, IOI President addresses the media.

IOI President plants memorial tree in Nyírerdő Nyírségi Erdészeti Zrt State Forest in honour of his visit to Hungary

The IOI President was invited to plant a memorial tree in Nyírerdő Nyírségi Erdészeti Zrt State Forest in honour of his visit to Hungary. The Commissioner for Fundamental Rights of Hungary, Dr Ákos Kozma, has a mandate to protect the rights of future generations. In recognition of this important mandate, and on the occasion of the IOI President's official visit to Hungary, it was a great honour for the IOI President to be invited to plant a memorial tree. The IOI President was also deeply humbled to be awarded the 2022 *Justitia Regnorum Fundamentum* Award granted by the Commissioner for Fundamental Rights of Hungary for "those who have achieved extraordinary, exemplary results in the field of protecting fundamental rights".

Left to right: Chris Field PSM, IOI President and Dr Ákos Kozma, Commissioner for Fundamental Rights of Hungary.

Plaque displayed on the occasion of Chris Field PSM, IOI President, planting a memorial tree in Nyírerdő Nyírségi Erdészeti Zrt State Forest in honour of his official visit to Hungary.

IOI President meets Dr. Tamás Sulyok, President of the Constitutional Court of Hungary, during visit to Hungary

The IOI President attended a meeting with the President of the Constitutional Court of Hungary, Dr. Tamás Sulyok, during his official visit to Hungary which was organised by the Commissioner for Fundamental Rights of Hungary, Dr Ákos Kozma.

Left to right: Dr. Tamás Sulyok, President of the Constitutional Court of Hungary and Chris Field PSM, IOI President.

IOI President attends meeting with the new Secretary General of the IOI, Ms Gaby Schwarz, during visit to Austria

Immediately prior to visiting Hungary, the IOI President was delighted to meet Ms Gaby Schwarz, the new Secretary General of the IOI and Chair of the Austrian Ombudsman Board, during his visit to Austria. This was the first meeting between the President and the new Secretary General, who is the first woman to hold the office of Secretary.

IOI President attends formal luncheon at the residence of His Excellency Mr Richard Sadleir, (former) Australian Ambassador to Austria and Head of the Permanent Mission to the United Nations in Vienna, in honour of his visit to Austria

Left to right: Gaby Schwarz, Secretary General of the IOI and Chair of the Austrian Ombudsman Board; His Excellency Mr. Richard Sadleir, (former) Australian Ambassador to Austria and Head of the Permanent Mission to the United Nations in Vienna; Chris Field PSM, IOI President; and Werner Amon, Minister for European and International Affairs, Education and Human Resources, Government of Styria and immediate former Secretary General, IOI.

The IOI President attended a formal luncheon at the private residence of His Excellency Mr Richard Sadleir, (former) Australian Ambassador to Austria and Head of the Permanent Mission to the United Nations in Vienna, in honour of his visit to Austria. The luncheon created an outstanding opportunity to discuss, at this critical time for both Europe and the world, the role of oversight agencies in promoting human rights and the rule of law.

IOI President attends meeting with His Excellency Mr Vasyl Myroshnychenko, Ambassador of Ukraine to Australia

The IOI President attended a meeting with His Excellency Mr Vasyl Myroshnychenko, Ambassador of Ukraine to Australia, as part of the Ambassador's visit to Western Australia. Ambassador Myroshnychenko and the IOI President had a warm and positive exchange and it was indicated to His Excellency that Western Australians, Australians and the IOI unequivocally support the people and sovereign nation of Ukraine.

Left to right: Rebecca Poole, Chief of Staff to the IOI President; Chris Field PSM, IOI President; and His Excellency Mr Vasyl Myroshnychenko, Ambassador of Ukraine to Australia.

IOI President attends meeting with His Excellency Mr Bruce Edwards, Australian Ambassador to Ukraine

The IOI President attended a meeting with His Excellency Mr Bruce Edwards, Australian Ambassador to Ukraine, as part of the Ambassador's official visit to Western Australia. The IOI President expressed his appreciation for the significant and gracious support offered to him by all Australian Ambassadors and the Department of Foreign Affairs and Trade in his role as IOI President.

Left to right: Chris Field PSM, IOI President and His Excellency Bruce Edwards, Australian Ambassador to Ukraine.

IOI President meets the Chief Minister of the Sindh Province and addresses the Launching Ceremony of a Research Study undertaken by the Provincial Ombudsman Sindh into Malnutrition and Stunting in Tharparkar

The IOI President met Chief Minister Sindh, His Excellency Syed Murad Ali Shah. His Excellency and the IOI President enjoyed a warm exchange and the IOI President was honoured that His Excellency presented him a traditional Sindhi cap and Ajrak, which the IOI President wore with great pride during his address at the Launching Ceremony of the Research Study "Assessment of Malnutrition (Stunting) in District Tharparkar" held in the main hall of the Chief Minister's House.

The Research Study, undertaken by the Provincial Ombudsman Sindh, is in the context that access to food and nutrition is a fundamental right for the citizens of Pakistan as enshrined in the Constitution. The IOI President was deeply pleased that this Research Study received funding through the IOI Regional Subvention Program that seeks to fund projects of significance in regions around the world.

Chris Field PSM, IOI President addresses the Launching Ceremony held in the Chief Minister's House.

Chris Field PSM, IOI President, at the Launching Ceremony held in the Chief Minister's House with dignitaries including (to the immediate right of the IOI President), Chief Minister Sindh, His Excellency Syed Murad Ali Shah; Ombudsman of the Sindh Province Ajaz Ali Khan; and Federal Ombudsman of Pakistan, Ejaz Ahmad Qureshi.

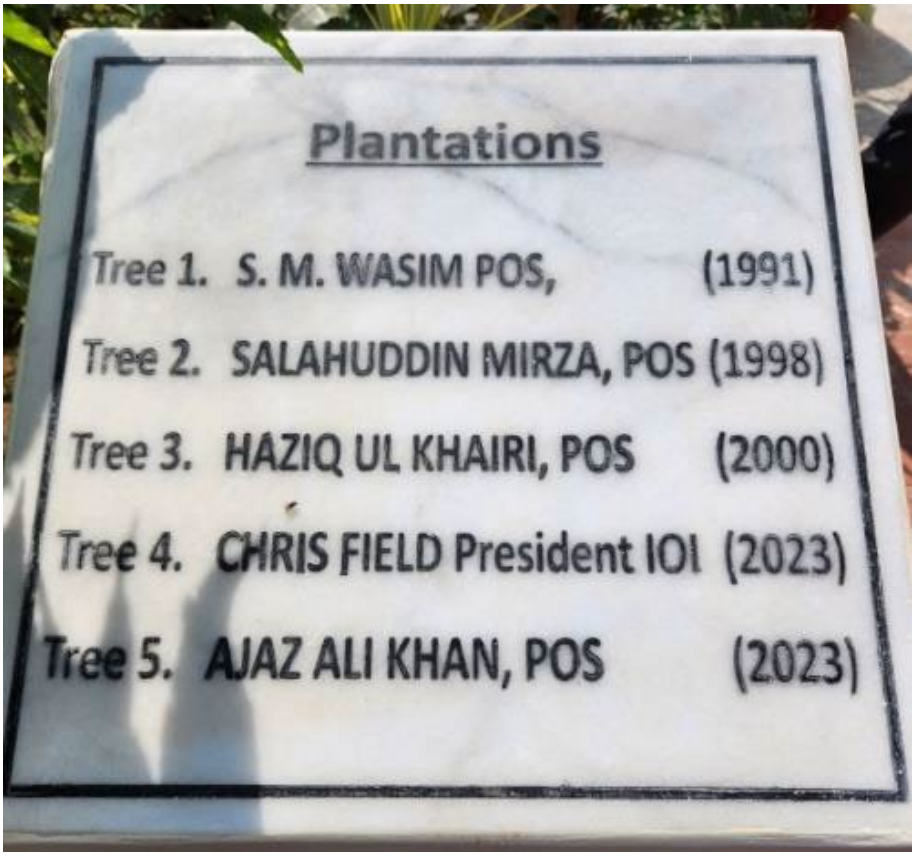
IOI President and Provincial Ombudsman Sindh jointly inaugurate new library and plant palm tree at the office of the Ombudsman Sindh

The IOI President was honoured to plant a palm tree in the gardens of the office of the Ombudsman Sindh. Alongside of this tree, Ombudsman Ajaz Ali Khan planted an identical tree, and a marble plinth memorialises this occasion. Following this, the IOI President was humbled to join Ombudsman Khan in jointly inaugurating the magnificent new library of the Provincial Ombudsman Sindh, again with a plaque that records this moment for posterity. From here, the IOI President enjoyed a very extensive and highly fruitful bilateral exchange with Ombudsman Khan and his senior executive, including an extensive question and answer session, as well as a separate meeting with Ombudsman Khan.

Left to right: Provincial Ombudsman Sindh, Ajaz Ali Khan and Chris Field PSM, IOI President, unveiling a plaque to commemorate the new library of the Provincial Ombudsman Sindh.

Provincial Ombudsman Sindh, Ajaz Ali Khan and Chris Field PSM, IOI President planting a tree.

Chris Field PSM, IOI President planting a tree.



A marble plinth to memorialise the occasion of a tree planting at the Provincial Ombudsman Sindh.

IOI President lays a floral wreath at the tomb of Muhammad Ali Jinnah, the revered founder of Pakistan, at the Mazar-e-Quaid Mausoleum

Following a Guard of Honour, a beautifully sung recitation of the Holy Quran and the Republic of Pakistan Naval Band playing the National Anthem of Pakistan, the IOI President laid a floral wreath inscribed with the details of his visit to Pakistan at the tomb of Muhammad Ali Jinnah, the revered founder of Pakistan, laid to rest in the Mazar-e-Quaid mausoleum. It was a deeply humbling and reverential occasion. The IOI President was then provided a private tour of both the Mausoleum and the museum of the Mausoleum, a perfectly preserved record of the great life of Muhammad Ali Jinnah.

Chris Field PSM, IOI President and Provincial Ombudsman Sindh, Ajaz Ali Khan, accompanied by dignitaries and senior officers of the Pakistan Navy (and Naval Band) lay an inscribed floral wreath at the at the tomb of Muhammad Ali Jinnah under full ceremonial Naval Guard.

Chris Field PSM, IOI President; Provincial Ombudsman Sindh, Ajaz Ali Khan, Rebecca Poole, Chief of Staff to the IOI President and other dignitaries lay an inscribed floral wreath at the at the tomb of Muhammad Ali Jinnah under Guard of Honour.

Chris Field PSM, IOI President; Provincial Ombudsman Sindh, Ajaz Ali Khan and other dignitaries lay an inscribed floral wreath at the at the tomb of Muhammad Ali Jinnah, followed by a sung recitation from the Holy Quran.

IOI President received by the Bishop of Karachi and Balochistan Diocese, visits Holy Trinity Cathedral and tours Mohatta Palace Museum

The IOI President was honoured to be received by the Right Reverend Frederick John, the Bishop of Karachi and Balochistan Diocese, for afternoon tea as well as visiting the exquisite Holy Trinity Cathedral. The Right Reverend John and the IOI President discussed the numerous good works that the Anglican Church undertake in the Sindh Province. The IOI President also toured the ornately beautiful Mohatta Palace Museum, which includes among its cultural treasures, vibrantly colourful handcrafted traditional clothing of the Sindh Province.

Left to right: The Right Reverend Frederick John, the Bishop of Karachi and Balochistan Diocese and Chris Field PSM, IOI President.

Left to right: The Right Reverend Frederick John, the Bishop of Karachi and Balochistan Diocese; Chris Field PSM, IOI President; and Rebecca Poole, Chief of Staff to the IOI President.

Chris Field PSM, IOI President and Rebecca Poole, Chief of Staff to the IOI President meet with the Right Reverend Frederick John, the Bishop of Karachi and Balochistan Diocese.

IOI President is guest of Federal Ombudsman of Pakistan and President of Asian Ombudsman Association at a formal working lunch

The IOI President was very pleased to accept the kind invitation of the Honourable Federal Ombudsman of Pakistan and President of the Asian Ombudsman Association, Ejaz Ahmad Qureshi, for a formal working lunch at the Sindh Club in Karachi. The working lunch was focussed on greater collaboration between the IOI and the Ombudsman institutions of Pakistan, as well as engagement with the Ombudsman of Asia.

IOI President meets Governor of Sindh Province, tours Government House and the National Museum of Pakistan

The IOI President had the privilege of meeting the Governor of Sindh, the Honourable Kamran Tessori, during his official visit to Pakistan. The Governor discussed matters not only regarding the Ombudsman institution, but also the very positive attitude that the people of the Sindh Province and Pakistan are bringing to recovery from both COVID-19 and tragic and devastating floods. Following the meeting with Governor Tessori, the IOI President enjoyed a tour of Government House provided by the Honourable Governor, followed by a comprehensive tour of the National Museum of Pakistan.

Left to right: The Honourable Kamran Tessori, Governor of Sindh; Chris Field PSM, IOI President; Ajaz Ali Khan, Provincial Ombudsman Sindh; and Rebecca Poole, Chief of Staff to the IOI President.

The Holy Quran in Bahar Script.

IOI flag being flown as Chris Field PSM, IOI President departs the Sindh Province, Pakistan.

IOI President addresses International Conference on the occasion of the 20th Anniversary of the Institution du Médiateur du Royaume (Maroc)

The IOI President had the great honour of providing a welcome address in the Opening Ceremony of the International Conference on the occasion of the 20th Anniversary of the Institution du Médiateur du Royaume (Maroc).

Chris Field PSM, IOI President, addresses International Conference on the occasion of the 20th Anniversary of the Institution du Médiateur du Royaume (Maroc).

The International Conference was held in the Academy of the Kingdom of Morocco in Rabat, a venue that features the most stunning expression of Moroccan architecture and which comfortably accommodated the 300 guests from around the world.

Later in the day, the IOI President was further delighted to address the Third Session of the conference on examining the Venice Principles and the United Nations Resolution on '*The role of Ombudsman and mediator institutions in the promotion and protection of human rights, good governance and the rule of law*'.

The International Conference on the occasion of the 20th Anniversary of the Institution du Médiateur du Royaume (Maroc).

Chris Field PSM, IOI President, attending the International Conference on the occasion of the 20th Anniversary of the Institution du Médiateur du Royaume (Maroc) with dignitaries, including (to the left of the IOI President), Mediator of the Kingdom of Morocco, Mohamed Benalilou.

Attendees of the International Conference on the occasion of the 20th Anniversary of the Institution du Médiateur du Royaume (Maroc).

IOI President undertakes cultural exchange in Rabat and Fes

The IOI President undertook cultural exchange in Rabat and Fes on the occasion of his visit to the Kingdom of Morocco. The Mediator of the Kingdom of Morocco, Mohamed Benalilou, took the IOI President on a tour of Fes El Bali, the ancient walled Medina, where they spent considerable time in the vast 9th century Karaouiyne University, a university originally founded as a Mosque by Fatima al-Fihri in 857–859. The tour included examining one of the most ancient copies of the Holy Quran in the world. The IOI President also met with expert craftspeople refurbishing and preserving invaluable Islamic texts that are many centuries old. The IOI President was provided a tour of the extraordinary site of the Royal Mausoleum of King Mohammed V, with a very large number of structures extant from the 12th century, including the Hassan Tower. From here, the IOI President visited the Kasbah of the Udayas, overlooking the Bou Regreg River, the Atlantic Ocean, the city of Salé and its stunning Andalusian gardens.

Left to right: Chris Field PSM, IOI President; Mohamed Benalilou, Mediator of the Kingdom of Morocco; and Şeref Malkoç, Chief Ombudsman of Turkey.

The City of Fez, Morocco.

One of the oldest versions of The Holy Quran in the world.

IOI President attends an official reception at the Residence of the Australian Ambassador to Morocco in honour of his visit to the Kingdom of Morocco

The IOI President was delighted to meet the Australian Ambassador to Morocco, His Excellency Michael Cutts and discuss a range of matters regarding the valued relationship between Australian and the Kingdom of Morocco, including that the Kingdom of Morocco has responsibilty for the UN Resolution on *The Role of the Ombudsman and Mediator Institutions in the Promotion and Protection of good governance, human rights and the rule of law*. The previous evening, the IOI President had the privilege of attending an official Reception in honour of his visit to the Kingdom of Morocco at the Residence of the Australian ambassador. The Mediator of the Kingdom of Morocco, Mohamed Benalilou and senior officers of the Mediator Institution were also guests of honour at this event.

Left to right: Chris Field PSM, IOI President, and His Excellency Michael Cutts, Australian Ambassador to Morocco.

The IOI President was also honoured that the Ambassador and Director for Asian Affairs and Oceania of the Kingdom of Morocco, His Excellency Abdelkader El Ansari attended, as did Ministre Déléguée Chargée de la Transition Numérique et de la Réforme de l'Administration, Ghita Mezzour, PhD. The President was further honoured that the Pakistan Ambassador to Morocco, His Excellency Hamid Asghar Khan; Indonesian Ambassador to Morocco, His Excellency H. Hasrul Azwar, MM and Korean Ambassador to Morocco, His Excellency Keeyong Chung attended. With each Ambassador, the IOI President discussed the deeply valued relationships that Western Australia and Australia share with Korea, Indonesia and Pakistan as well as matters of importance to the role of the Ombudsman.

IOI President meets with the Mediator of the Kingdom of Morocco, Mr Mohamed Benalilou

The IOI President met with the Mediator of the Kingdom of Morocco, Mr Mohamed Benalilou. Following the meeting, the IOI President undertook a press conference and toured the office of the Mediator. The IOI President was given the honour of signing a very large framed replica of the postage stamp commemorating the 20th anniversary of the Institution that is displayed in the reception of the office of the Mediator of the Kingdom of Morocco. The postage stamp also bears the signatures of the Mediator and the Director General of the Barid Al-Maghrib (the Moroccan Postal Service).

Left to right: Mohamed Benalilou, Mediator of the Kingdom of Morocco and Chris Field PSM, IOI President.

IOI President chairs the 2023 World Board Meeting of the IOI in Vienna

The IOI President had the pleasure of chairing the 2023 meeting of the World Board of the IOI in Vienna (and the Executive Committee meeting of the World Board and the United Nations Working Group meeting of the World Board).

Members of the Executive Committee of the World Board of the IOI.

Left to right: Caroline Sokoni, IOI Treasurer; Gaby Schwarz, IOI Secretary General; Peter Boshier, IOI Second Vice-President; Chris Field PSM, IOI President; Diane Welborn, IOI First Vice-President; Nashieli, Ramírez Hernández Regional President Caribbean and Latin America Region of the IOI; Somsak Suwansujarit, Regional President Asia Region of the IOI; and Andreas Pottakis, Regional President European Region of the IOI.

Left to right: Gaby Schwarz, Secretary General of the IOI and Chair of the Austrian Ombudsman Board; Chris Field PSM, IOI President; and Rebecca Poole, Chief of Staff to the IOI President.

Chris Field PSM, IOI President, chairs the meeting of the UN Working Group of the World Board of the IOI.

Left to right: Peter Kostelka, former Secretary General of the IOI; Antonia Florbela De Jesus Rocha Araujo, Provedoria de Justiça de la República de Angola; Florence Kajuju, IOI Africa Regional President and Ombudsman, Commission on Administrative Justice (Ombudsman) of Kenya; Chris Field PSM, IOI President; Kholeka Gcaleka, Acting Public Protector of South Africa, Caroline Sokoni, IOI Treasurer and Public Protector Zambia; and Mats Melin, former President of the IOI.

IOI President provides a Welcome Address to a Reception and charity event co-hosted by the Ukraine Ambassador to Austria, His Excellency Dr Vasyl Khymynets and the charity, Voices for Children

The IOI President was deeply honoured to provide a Welcome Address to a Reception and charity event co-hosted by His Excellency Dr Vasyl Khymynets, the Ukraine Ambassador to Austria, and the charity, Voices for Children. The IOI President was joined by his dear friend Dmytro Lubinets, Ukrainian Parliament Commissioner for Human Rights, as well as His Excellency Dr. Michael Carpenter, US Ambassador to the Organization for Security and Co-operation in Europe and His Excellency Bruce Edwards, Australian Ambassador to Ukraine.

Left to right: Chris Field PSM, IOI President, providing a Welcome Address, alongside fellow distinguished speakers Dmytro Lubinets, Ukrainian Parliament Commissioner for Human Rights, and Dr Vasyl Khymynets, Ukrainian Ambassador to Austria.

Left to right: Chris Field PSM, IOI President, Dmytro Lubinets, Ukrainian Parliament Commissioner for Human Rights, and Dr Vasyl Khymynets, Ukrainian Ambassador to Austria.

IOI President presents the Golden Order of Merit for exceptional service to the IOI to former IOI Regional President Europe and Catalan Ombudsman, Mr Rafael Ribó, in Vienna

The IOI President had the privilege of presenting the Golden Order of Merit to former IOI Regional President Europe and Catalan Ombudsman, Mr Rafael Ribó, during his visit to Austria.

Chris Field PSM, IOI President, providing an address at the Golden Order of Merit ceremony for Mr Rafael Ribó.

Mr Rafael Ribó receiving the Golden Order of Merit.

IOI President attends a formal Welcome Reception to the World Board of the IOI at the Australian Embassy in Vienna in honour of his visit to Austria

In honour of the IOI President's visit to Austria, the Chargé d'Affaires of the Australian Embassy in Vienna, Mr Emil Stojanovski, invited a large number of guests to the Australian Embassy for a formal Welcome Reception to the World Board of the IOI. The IOI President was delighted to provide a Welcome Address to his colleagues.

It was a further honour that the Australian Ambassador to Ukraine, His Excellency Mr Bruce Edwards, was able to attend on an evening where the IOI President's special guest was the Ukrainian Parliament Commissioner for Human Rights, Mr Dmytro Lubinets. A further special guest was former IOI Regional President Europe and Catalan Ombudsman, Mr Rafael Ribó, and recipient earlier that evening of the Golden Order of Merit for his exceptional service to the IOI.

Left to right: Chris Field PSM, IOI President and Emil Stojanovski, Chargé d'Affaires of the Australian Embassy in Austria.

Chris Field PSM, IOI President addressing the Welcome Reception.

IOI President presents guest of honour of the 2023 IOI World Board meeting in Vienna, the Ukrainian Parliament Commissioner for Human Rights, Dmytro Lubinets

The IOI President was honoured to introduce Ukrainian Parliament Commissioner for Human Rights, Dmytro Lubinets, as the guest of honour at the meeting of the 2023 World Board of the IOI in Vienna. Alongside of Commissioner Lubinets, the IOI President was deeply grateful that the Australian Ambassador to Ukraine, His Excellency Bruce Edwards, was able to join the IOI President and Commissioner Lubinets for the presentation.

Dmytro Lubinets, Ukrainian Parliament Commissioner for Human Rights (centre) presenting to the 2023 IOI World Board at the invitation of Chris Field PSM, IOI President.

His Excellency Bruce Edwards, Australian Ambassador to Ukraine, at the World Board meeting presentation.

IOI President attends an official Reception at the Parliament of Austria hosted by the President of the Austrian National Council, His Excellency Wolfgang Sobotka

The IOI President had the privilege of being provided a private tour of the Austrian Parliament, along with IOI World Board colleagues. The IOI President and the IOI World Board were welcomed to the Parliament by the President of the Austrian National Council, His Excellency Mr Wolfgang Sobotka and the IOI President was honoured to give the speech in response and renew his acquaintance with His Excellency. In the evening, the IOI World Board had a formal dinner at the Parliament.

IOI World Board members tour the Austrian Parliament and are welcomed by President of the Austrian National Council, His Excellency Wolfgang Sobotka.

Left to Right: His Excellency Mr Wolfgang Sobotka, President of the Austrian National Council and Chris Field PSM, IOI President.

Left to Right: His Excellency Mr Wolfgang Sobotka, President of the Austrian National Council and Chris Field PSM, IOI President.

IOI President provides the commemoration speech for the presentation of the Golden Order of Merit to former IOI Secretary General, Minister Werner Amon

The IOI President provided a commemoration speech for the presentation of the Golden Order of Merit to former IOI Secretary General, Minister Werner Amon MBA, a very rare award reserved only for those who make an exceptional contribution to the IOI. Among other things, the Minister changed the status of the IOI as an international institution under Austrian law, achieved a significant increase in resources and staff for the General Secretariat of the IOI and, with his Austrian Ombudsman Board colleagues achieved GANHRI "A" Status, for the Austrian Ombudsman Board. The ceremony followed the IOI's official side event in Styria, where guests were incredibly graciously welcomed by the Governor of Styria, His Excellency Mr Christopher Drexler.

Chris Field PSM, IOI President, providing the commemoration speech for the presentation of the Golden Order of Merit to former IOI Secretary General, Minister Werner Amon.

Left to right: Chris Field PSM, IOI President and Werner Amon MBA, Minister for Education, Human Resources, Europe and International Affairs.

IOI President undertakes cultural exchange in Graz and Styria at the invitation of Werner Amon MBA Minister for Education, Human Resources, Europe and International Affairs

The IOI President undertook an official visit to Graz and Styria at the invitation of the Minister for Education, Human Resources, Europe and International Affairs, Minister Werner Amon MBA. Graz was the first European human rights city, is multicultural and a city of the richest history and art. Styria is home to advanced manufacturing, including cars, semi-conductors, pharmaceuticals and new energy sources. The visit included private guided tours of the Schloss Eggenberg and and the modern art museum, the Kunsthaus Graz.

Left to right: Arthur Winker-Hermaden, Chief of Cabinet to Minister Amon; Chris Field PSM, IOI President; Werner Amon MBA, Minister for Education, Human Resources, Europe and International Affairs; Meinhard Friedl, Head of International Affairs for Minister Amon; and Barbara Schrank, International Coordination, Office of Minister Amon.

Chris Field PSM, IOI President, at the Lannach Spring Festival where he was given the honour of conducting the Lannach Band in a rendition of the Josef Niggas March. The March was specifically composed to honour the birthday of Herr Burgermeister, Josef Niggas, such a popular Mayor that he has served for 28 years, with increased support at each election.

IOI President meets the President of the Republic of Slovenia, Dr Nataša Pirc Musar, at the Presidential Palace, on the occasion of his visit to Slovenia

The IOI President had the honour of meeting the President of the Republic of Slovenia, Dr Nataša Pirc Musar, at the Presidential Palace, on the occasion of his visit to Slovenia. Her Excellency, the first woman to hold the office of President, has a deeply impressive background. President Pirc Musar and the IOI President had a highly positive meeting regarding the work that must be done to protect human rights and act on climate change, among other important matters.

Left to right: Chief of Staff to the IOI President, Rebecca Poole, Chris Field PSM, IOI President; Human Rights Ombudsman of the Republic of Slovenia, Peter Svetina; President of the Republic of Slovenia, Dr Nataša Pirc Musar.

Left to right: Peter Svetina, Human Rights Ombudsman of the Republic of Slovenia; Dr Nataša Pirc Musar, President of the Republic of Slovenia; and Chris Field PSM, IOI President.

IOI President accompanies President Pirc Musar to the day care centre, Hiša dobre volje, in Miren near Nova Gorica, on the occasion of his visit to Slovenia

It was a great privilege for the IOI President to accompany President Pirc Musar and Human Rights Ombudsman Peter Svetina to visit the day care centre, Hiša dobre volje, in Miren near Nova Gorica, which is a unit of Nova Gorica Home for the Elderly, where individual support is championed and the inclusion of older people in the community in their home environment is promoted.

Dr Nataša Pirc Musar, President of the Republic of Slovenia; Chris Field PSM, IOI President; Peter Svetina, Human Rights Ombudsman of the Republic of Slovenia; and Rebecca Poole, Chief of Staff to the IOI President, with members of the community at the Nova Gorica Home for the Elderly.

Chris Field PSM, IOI President, visits the Hiša dobre volje, at the Nova Gorica Home for the Elderly.

IOI President undertakes a live interview for the RTV Channel 1 Slovenia program, Odmevi

On the occasion of his visit to Slovenia, the IOI President was very pleased to undertake a live interview for the RTV Channel 1 Slovenia program, Odmevi. Odmevi is Slovenia's most viewed news television show and offers evening news analysing the most important events of the day.

Chris Field PSM, IOI President, being interviewed by Mr Igor Bergant.

IOI President meets President of the National Assembly of the Republic of Slovenia

It was an honour for the IOI President to meet the President of the National Assembly of the Republic of Slovenia, Ms Urška Klakočar Zupančič. Her Excellency has a strong interest in human rights and the meeting was an exceptionally enjoyable and wide-ranging discussion about the role of the Ombudsman, IOI and the many significant human rights achievements in Slovenia. President Zupančič, the first woman to hold this very senior office, could not have been more generous with her time.

Left to right: Chris Field PSM, IOI President and Urška Klakočar Zupančič, President of the National Assembly of the Republic of Slovenia.

Left to right: Chris Field PSM, IOI President; Urška Klakočar Zupančič, President of the National Assembly of the Republic of Slovenia; and Peter Svetina, Human Rights Ombudsman of the Republic of Slovenia.

IOI President meets the Minister of Justice of the Republic of Slovenia, Dr Dominika Švarc Pipan

The IOI President had the great pleasure of meeting the Minister of Justice of the Republic of Slovenia, Dr Dominika Švarc Pipan, on the occasion of his visit to Slovenia.

The Minister is a very impressive leader and the IOI President and the Minister enjoyed a particularly warm exchange. The IOI President and the Minister discussed the work of the IOI and the work of Ombudsman institutions to uphold the great principles of justice, human rights and the rule of law.

Left to Right: Peter Svetina, Human Rights Ombudsman of the Republic of Slovenia; Dr Dominika Švarc Pipan, the Minister of Justice of the Republic of Slovenia; and Chris Field PSM, IOI President.

Left to Right: Peter Svetina, Human Rights Ombudsman of the Republic of Slovenia; Chris Field PSM, IOI President; Rebecca Poole, Chief of Staff to the IOI President; and Dr Dominika Švarc Pipan, the Minister of Justice of the Republic of Slovenia.

IOI President meets the Minister for Relations between the Republic of Slovenia and Slovenians Abroad, Mr Matej Arčon

The IOI President had the pleasure of meeting Mr Matej Arčon, Minister for Relations between the Republic of Slovenia and the Autochthonous Slovenian National Community in Neighbouring Countries, and between the Republic of Slovenia and Slovenians Abroad. Minister Arčon and the IOI President had a very enjoyable and productive discussion regarding the work of the IOI and its more than 200 members from over 100 countries.

Left to right: Matej Arčon, Minister for Relations between the Republic of Slovenia and the Autochthonous Slovenian National Community in Neighbouring Countries, and between the Republic of Slovenia and Slovenians Abroad; Rebecca Poole, Chief of Staff to IOI President; Chris Field PSM, IOI President; Vesna Humar, State Secretary Government Office for Slovenians Abroad; and Peter Svetina, Human Rights Ombudsman of the Republic of Slovenia.

Chris Field PSM, IOI President, at the office of the Minister for Relations between the Republic of Slovenia and the Autochthonous Slovenian National Community in Neighbouring Countries, and between the Republic of Slovenia and Slovenians Abroad.

IOI President undertakes significant cultural exchange, visiting Postojna Cave, Lake Bled and Piran

Alongside bilateral exchanges and a number of meetings with the most senior members of Government, the IOI President was given the great honour of undertaking cultural exchange in Slovenia.

One such place was Postojna Cave, where the IOI President was privileged to be given a personalised welcome and a private guided tour. At the end of the tour, the IOI President was asked to sign the “Golden Book” of visiting dignitaries, first signed by Hasburg Emperor Franz Joseph. The IOI President also visited Lake Bled and was provided a private guided tour by the former Mayor.

The IOI President and Ombudsman Svetina were also shown, and operated, a replica Gutenberg press. As a final visit in Slovenia, the IOI President travelled to Piran, a town of great historic importance on the Adriatic Sea, in the southwest of Slovenia.

Chris Field PSM, IOI President, signing the “Golden Book” of visiting dignitaries.

Welcome message to Chris Field PSM, IOI President, and Rebecca Poole, Chief of Staff to the IOI President, displayed at the entrance of Postojna Cave.

IOI President meets with the Agent General for Western Australia in the United Kingdom/Europe Region, Mr John Langoulant AO

The IOI President met with the Agent General for Western Australia in the United Kingdom/Europe region, Mr John Langoulant AO, and followed this with a visit to his offices at Australia House.

The IOI President and Agent General discussed the work of the IOI and the Agent General's outstanding work in promoting important investment attraction, trade promotion and state representation for Western Australia within the United Kingdom and European markets.

Left to Right: John Langoulant AO, Agent General for Western Australia in the United Kingdom/Europe Region; Chris Field PSM, IOI President; and Rebecca Poole, Chief of Staff to the IOI President.

IOI President meets with His Excellency the Honourable Mr Stephen Smith, Australian High Commissioner to the United Kingdom

Immediately following his visit to Slovenia and immediately prior to his visit to Manchester, it was a great pleasure for the IOI President to meet with His Excellency the Honourable Mr Stephen Smith, Australian High Commissioner to the United Kingdom, on the occasion of the IOI President's official visit to London. The meeting took place in the High Commissioner's office at the Australian High Commission in Australia House, London.

Following a distinguished senior Ministerial career in the Australian Government, the High Commissioner undertakes vital work with one of Australia's closest and most important friends.

IOI President attends the offices of Ombudsman Behrens

The IOI President and Ombudsman Behrens met at his Citygate offices in Manchester.

Left to right: Ombudsman Behrens and Chris Field PSM, IOI President.

The Parliamentary and Health Services Ombudsman of the United Kingdom is one of the world's largest and best-regarded Ombudsman offices, led by Ombudsman Behrens and his senior executive team. A tour of the office was a chance to hear from, and discuss issues with, deeply knowledgeable, dedicated and passionate staff; a series of briefings from senior staff exemplified Ombudsman best practice; and a deeply enjoyable Q and A session with 250 staff finished the day.

IOI President provides address at the Parliament of New Zealand on the occasion of the 60th Anniversary of the Office of the Ombudsman of New Zealand

The IOI President joined the Honourable Chris Hipkins, (then) Minister for the Public Service (and now Prime Minister of New Zealand) and the IOI Second Vice President and Chief Ombudsman of New Zealand, Peter Boshier, in addressing a very special event held at the Parliament of New Zealand to celebrate the 60th Anniversary of the Ombudsman of New Zealand.

Left to right: Chris Field PSM, IOI President; Peter Boshier, IOI Second Vice President and Chief Ombudsman of New Zealand; and Hon Chris Hipkins, (then) Minister for the Public Service (and now Prime Minister of New Zealand).

Chris Field PSM, IOI President providing an address at the 60th Anniversary of the Ombudsman of New Zealand.

IOI President meets with Her Excellency Ms Harinder Sidhu, Australian High Commissioner to New Zealand, during official visit to New Zealand

The IOI President met with Her Excellency Ms Harinder Sidhu, Australian High Commissioner to New Zealand, at the Australian High Commission in Wellington. The IOI President and Her Excellency discussed the work of the IOI and Ombudsman institutions, both in Australia and New Zealand, but also at this most critical time in Europe and globally.

IOI President presents the Golden Order of Merit to two former IOI Presidents, and Life Members, of the IOI, during official visit to New Zealand

The IOI President presented the Golden Order of Merit to two former IOI Presidents, and Life Members of the IOI, Dame Beverley Wakem DNZM CBE and Sir Brian Elwood CBE JP. The Golden Order of Merit recognises exceptional contribution in respect of the purposes of the IOI. Sir Brian was the President of the IOI between 1999 and 2002. Dame Beverley was President between 2010 and 2014 and the first woman to hold the position of Chief Ombudsman of New Zealand.

Left to right: Peter Boshier, Chief Ombudsman of New Zealand; Dame Beverley Wakem DNZM CBE; Chris Field PSM, IOI President; Sir Brian Elwood CBE JP; and Deborah Glass, Victorian Ombudsman and IOI Reginal President.

IOI President attends annual conference of the Australasian and Pacific Ombudsman Region, in Wellington

The IOI President attended the annual conference of the Australasian and Pacific Ombudsman Region, in Wellington, New Zealand. The conference was led by IOI Regional President and Victorian Ombudsman, Deborah Glass, and hosted by IOI Second Vice President and Chief Ombudsman of New Zealand, Peter Boshier.

Members of the Australasian and Pacific Ombudsman Region of the IOI.

IOI President's addresses

In 2022-23, the IOI President:

- Provided a Welcome Address to the International Mediation Congress, *An approach to Conflict in the Global Agenda*, held in Rosario, in the province of Santa Fe, Argentina, from 5 to 7 July 2022;
- Participated in a live panel discussion at the commencement of the final day of the International Mediation Congress, *An approach to Conflict in the Global Agenda*, held in Rosario, in the province of Santa Fe, Argentina, on 7 July 2022;
- Provided a briefing on the Office of the Ombudsman's current work program, to the Public Sector Commission Leadership Council, in August 2022;
- Provided a Welcome Address at the international conference, *The rights of older persons and role of ombudsman and mediator institutions*, held in Tbilisi, Georgia, on 27 September 2022;

- Provided an address at the Parliament of New Zealand on the occasion of the 60th Anniversary of the Ombudsman of New Zealand, in October 2022;
- Provided a keynote address at the Conference for Ombudspersons and National Human Rights Institutions within the framework of the First Parliamentary Summit of Crimea Platform, on 26 October 2022;
- Provided a keynote address on the occasion of a ceremony to celebrate the 30th anniversary of the Croatian Ombudsman, on 30 November 2022;
- Provided an address to the 32nd Annual Silent Domestic Violence Memorial March, on 29 November 2022;
- Provided a keynote address on the occasion of an international conference and celebration of the 30th anniversary of the Cyprus Ombudsman, on 2 December 2022;

Chris Field PSM, IOI President addresses international conference by virtual means from Perth Western Australia

- Spoke in the opening ceremony at the International Conference, *Human Rights in Dark Hours*, in Ukraine, on 9 December 2022;
- Provided a keynote session and closing session, *A career in law and Q&A* to University of Western Australia students as part of the Government Accountability Law and Practice Unit, in January 2023;
- Provided a welcome address at the International Conference on the occasion of the 20th Anniversary of the Institution du Médiateur du Royaume (Maroc), and an address at the third session of the conference on *The role of Ombudsman and mediator institutions in the promotion and protection of human rights, good governance and the rule of law* on 28 February 2023;
- Provided an address at the Launching Ceremony of a Research Study undertaken by the Provincial Ombudsman Sindh into malnutrition and stunting in Tharparkar, on 13 March 2023; and
- Provided a welcome address to a reception and charity event in Vienna, Austria, co-hosted by the Ukraine Ambassador to Austria, His Excellency Dr Vasyl Khymynets and the charity, Voices for Children, on 7 May 2023.

Video recorded and written speeches by the Ombudsman as President of the IOI are available on the President's Speeches and Engagements page of the Ombudsman's website.